

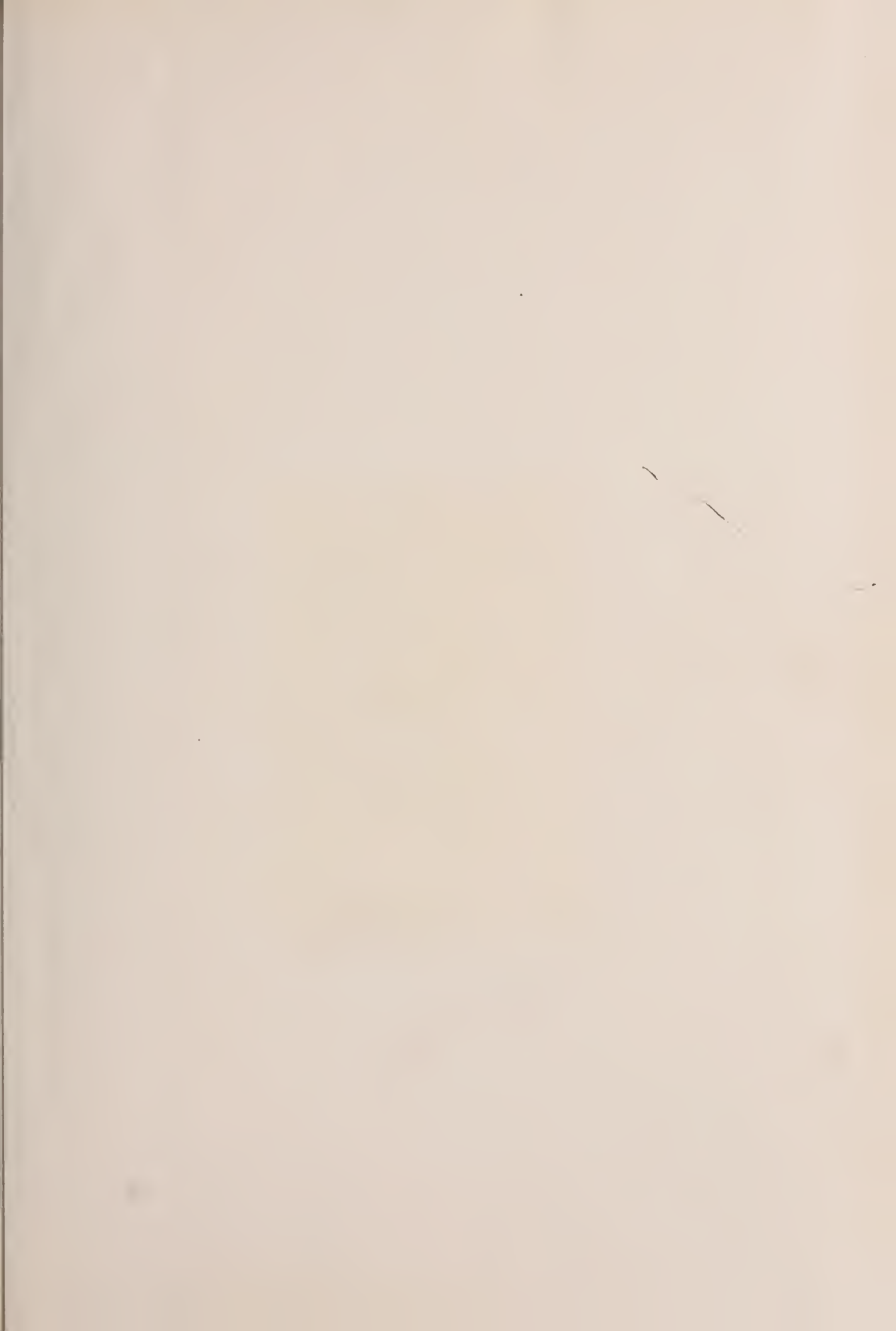
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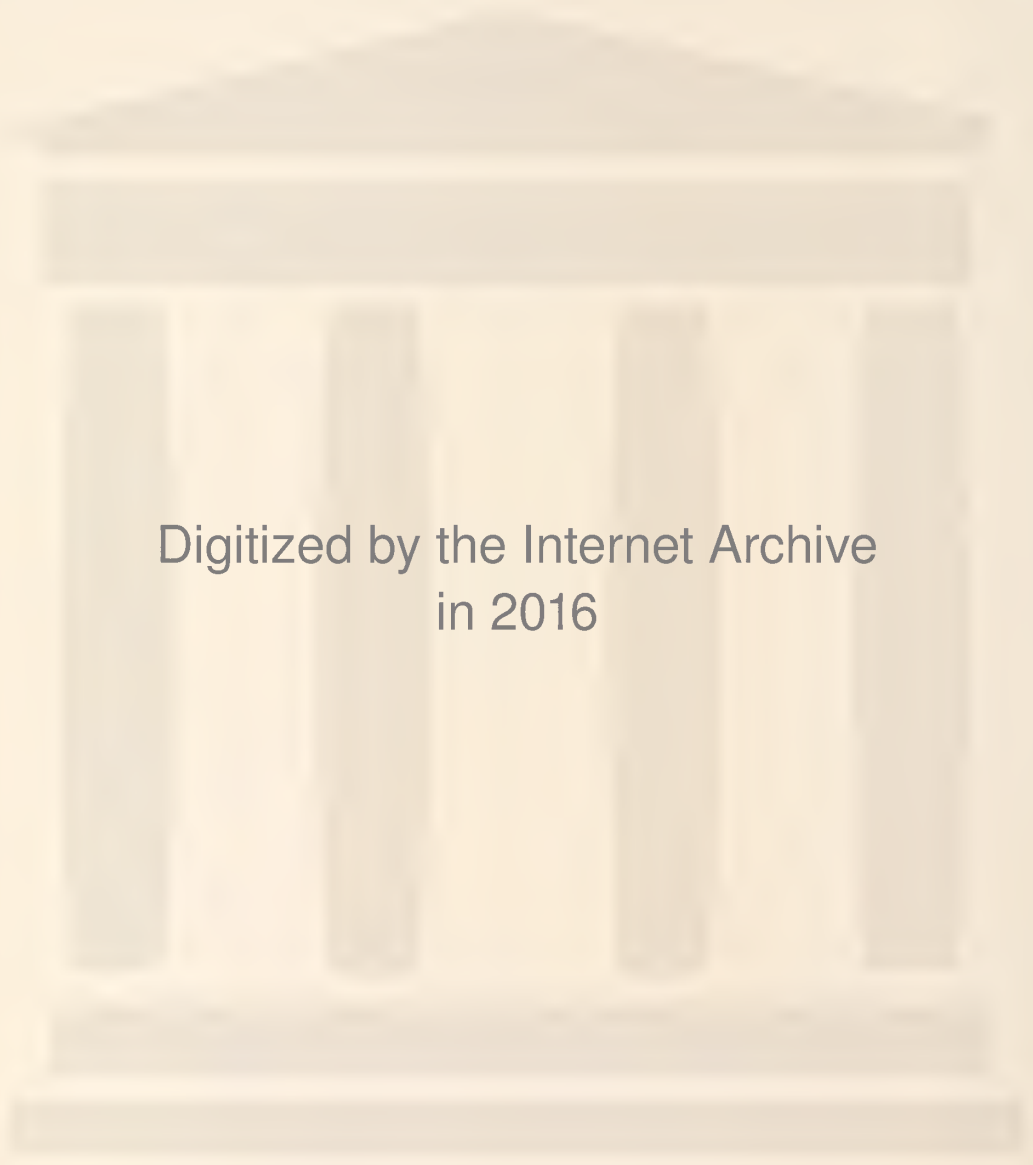
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JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

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1. Gordon, E. E. and Haas, A., *Indust. Med. & Surg.* 28:217, May, 1959.



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EDITORIALS

The Physician And The Library

It is quite possible to practice a skilled craft without any reference to books or journals. There is, to be sure, a learnable skill in paper-hanging, beef-cutting, and television repairing. But most craftsmen in these fields function without frequent reference to the literature of their work. It is, however, not possible to practice medicine or law without being back-stopped by a library. We need books to recall the structure and functions of organs and organisms, the indications, untoward effects, and doses of drugs, the fine points of differential diagnosis, the relative advantages of different therapeutic regimes. No matter how rich the practitioner's experience with the tissue, the disease, or the human being, he still needs the intellectual stimulus of the medical book and the up-to-dateness that can come only from a current journal. A physician who has not opened a text or journal since he got out of medical school is going to freeze his practice, intellectually, at the level it was at that time. There are, one suspects, some physicians who have not so refreshed themselves, but for the most part, they aren't saying so. Ours is a *learned* profession, and a man of learning does not confess that he needs it no longer. The linguists are not sure whether, etymologically, *doctor* means "he who teaches," or "he who is taught." At any rate, *learning* in our culture means printed matter as well as talking, observing, experiencing, and seeing.

So, the medical practitioner without access to journals and books is a man without tools of learning, without a major source of intellectual refreshment. And so fast is the pace of medical progress that we can no longer get along with a modest five-foot shelf and a subscription to one specialty or family-medicine journal. We need access to a library, and experience in retrieving its con-

tents. The physician who stops turning the pages of texts and who stops looking at medical journals is telling his colleagues that he now has all the answers. In addition to the well-stocked state-wide library of the Academy of Medicine, there are libraries in both medical schools and in most of the larger hospitals. We, of all people, shouldn't need some kind of National Library Week to tell us about these storehouses of useful knowledge. We must, each of us, know where to find these libraries and how to use them. To neglect this kind of facility is to write *finis* to self-improvement and so announce that we have reached the end of our learning.

The Fall And Rise Of Uroscopy

Ancient pictures show the venerably gowned physician gazing solemnly at a glass of urine. He holds the specimen up to the light and looks wisely at it. This process called uroscopy, was one of the medical mysteries taught only to initiates. Without microscope or chemical tests, the medieval doctor looked through the urine and detected more things wrong than a chiropractor can see in one of his "spinographs."

With the advance of medical knowledge, it became apparent that there was a lot of hocus pocus in uroscopy. So the art became discredited. When simple tests were developed for acidity, sugar, and albumin, the process was redesignated "urine analysis" (syncopated into urinalysis) and became the *pons asinorum* for medical students and medical technologists.

Those of us who have not been close to biochemistry or internal medicine may not realize the extent to which urine analysis has become a major diagnostic tool. In addition to the original quarries—acidity, sugar, albumin, casts, blood, and pus, the modern technologist now hunts for cystine, tyrosine, porphyrins, creatinine, bile, and hormones. He

looks for indican, spermatozoa, fat, uric acid, phosphates, and acetone bodies. He no longer leans on simple inspection, or even on microscopy. Instead he depends on turbidimetry, dialysis, colorimetry, and spectrum analysis. The urine gives information about absorption of antibiotics, fluid balance, sugar metabolism, kidney function, and pregnancy.

Urine, after all, is not simply a bodily reject. It is an inherent part of the human fluid cycle, a portable culture medium for bacteria, and, when properly interpreted, a veritable signal corps of disease. Urine analysis, once scorned as the primer for interns, has again become a serious and major branch of human diagnostics.

Call Me Mister

A favorite conversational topic in the residents' lounge is whether to call a patient by his first name. This is something they don't teach in medical school. However, a little reflection will show that, in the American culture, aside from family and old-friends, first names are associated with patronage and inferiority. To call the bootblack "Bill" and the elevator operator "Mike" is to patronize him. It is not a token of familiarity among equals unless it moves on a two-way street. If the patient called by his first name must use "Doctor" in return, this is not an expression of equality.

The use of the last name without the "Mister" is almost un-American. It has a contumacious air about it. Nearly always a man feels uncomfortable when he is called just "Jones" or "Miller." Traditionally, it is the label of the servant—the butler is Jeeves, after all, not Mr. Jeeves and not Conrad but just plain Jeeves.

In the big wonderful world of business, the fashion now is to use initials. To call the boss Mr. Auchinschloss sounds as if you are way below him; to call him Joe would be undue familiarity. So you call him J. A. which nicely bridges the gap.

Sometimes another variable is introduced: the title. You can solve all these problems if you can call the man "Professor," "Judge," "Doctor," or "Colonel." The titles themselves have a curious anonymity. By stripping the man of what is idiomatically his—his personal name—and falling back on a title (which he shares with a hundred thousand others) you avoid involving yourself too much. The title is thus a comfort to the one who uses it, for it saves him the problem of measuring his exact relationship to the other. And it is a comfort to the one who is so addressed, since it is usually an honorific. In some countries almost every educated man has a title. (Cuba's Castro is, believe it or not, properly called "Doctor" though he never studied medicine; and in France, every lawyer is "Maitre.") And wherever it is desired to squeeze personalities out of a relationship, formal titles abound—the Army being the obvious example.

In some primitive religions a man's name was private, for it was feared that if you knew his name you thereby acquired some mystic power over him. To this day, many people have a vague feeling of discomfort at making known their names. (Sometimes when you ask, you get as a reply: Why do you want to know?) Our Bible says: "As his name is, so is he." And the glory and hallowing of Names (usually with a capital N) appears frequently in the Bible.

Names, too, confer immortality. A man may die, but his sons and their sons carry on the name, until that name seems to acquire a life of its own. The loss of a name is a symbol of degradation. (Remember the old song: "She was poor but she was honest and her parents were the same; till she came into the city and she lost her honest name.")

We usually don't give much thought to whether we call or are called by a first name, by initials, by a title, or by a last name—it all seems to be automatic. But it isn't. It is motivated by unconscious factors which reflect the roles of the two persons concerned.

About patients, the general rule is simple. When in doubt, call him Mister.

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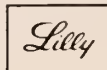
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ORIGINAL ARTICLES

Instead of another requiem for the GP, we can do something about the problem, suggests Dr. Brodtkin.

A Second Look At Family Practice

Henry A. Brodtkin, M.D./East Orange

One reason that medical services in the United States are overburdened, inadequately distributed, and inefficiently utilized is the diminishing number of doctors entering general practice. This supports the statement of President Nixon that, "We are faced with a major crisis if immediate action is not taken."

This world-wide problem was discussed in a four-day symposium at the World Medical Assembly in Oslo, Norway, last summer. Legislation is being prepared in our Congress to provide free medical care by 1975 to all who need it and can't afford it. This huge burden will be borne by the general practitioners who take care of about 85 per cent of medical needs. Much lip service was given to the "dedication" and "arduous duties" of the general practitioner, and many suggestions were made to encourage more doctors to enter general practice. There was little reference to what produced the situation, nor was there agreement as to how to cope with it.

Before World War II, a general practitioner, in cities as well as in rural areas, was held in high esteem by the public and the medical profession. He was the family advisor in all health matters. He delivered the babies and treated all medical and surgical problems except those requiring a specialist. He unhesitatingly sought a specialist for consultation and special treatment when required, but continued in the general treatment of the patient.

After World War II, polarization in the medical profession spread rapidly. We had general practitioners and specialists and, among the latter, certified and non-board certified. Hospital accreditation came into being and added to the polarization by requiring hospital rules that gave board diplomates preferential staff positions and froze out the general practitioner. Gradually the GPs' privileges were so reduced that his patients who required hospitalization were taken over by internists, surgeons, pediatricians, or obstetricians. He was no longer permitted to assist at operations although nurses and interns could. Burgeoning medical insurance plans created a scarcity of hospital beds. It, then, became more difficult for the general practitioner to admit and treat his patient in most hospitals. The role of the specialist in hospital practice became enormously glorified to the viewing public on television and radio. Gradually the general practitioner became the second class citizen of the profession to specialists and the public. The phrase, "he is only a general practitioner," was more commonly heard in beauty parlors, restaurants, and among specialists. If a specialist was seen making a house call (on a prestigious or rich patient) he usually gave profuse excuses. Thus the prestige of the specialist rose and that of the general practitioner tumbled. After twelve years, the Academy of General Practice changed its name to the American Academy of Family Practice. This change reflects a subconscious feeling of inferiority in the status of *general practitioner*.

At the World Medical Assembly, representatives from many nations sang a doleful dirge about the dwindling number of general practitioners in their countries. Some spoke of the steps that have been taken to rectify it. Sixteen countries reported the establishment of General Practitioner Associations. Since 1966, thirteen countries have established 24 university chairs of general practice with Canada leading with 7, Netherlands with 4, and Norway and Great Britain with two each. These are all formal departments of family or general practice and staffed by general practitioners. Eighteen medical colleges have made provisions for courses in general practice requiring practical experience of their students. All speakers agreed that the first step was to start at the undergraduate level to teach and train students for general practice. Most speakers agreed that post-graduate lectures, meetings, and short courses were inadequate. All agreed that steps must be taken to raise the status and prestige of the general practitioner and that it was essential to provide him with specific periodic refresher courses.

A summary of what some countries are doing about this problem follows:

In *South Africa*, the Pretoria Medical School has a division of Family Medicine and offers a full-time one year course to a Masters Degree in Family Medicine. South African medical schools conduct week long refresher courses for general practitioners.

Norway provides graduate courses and continuous education programs for general practitioners, including an intensive eighteen months post-internship program. Every year an intensive two-week course is provided. Every five years, the Norwegian general practitioner spends three months (full-time) in a hospital program. In the medical schools at Oslo and Bergen there are new chairs in family practice. The expenses will be borne for the first five years by the Norwegian Medical Association.

In *Great Britain*, the Royal College of Gen-

eral Practitioners arranges courses for family practitioners. The government pays the costs for travel and subsistence for the family doctors taking these courses.

Canada has the most innovative and effective program in the English speaking world for general practitioners. The ambitious family doctor is encouraged to take at least 100 hours of graduate training in each biennium. Special educational grants are available in the funding.

In the *United States*, credit for the effort to improve the status of the general practitioner must be given to the Academy of Family Practice. The AMA Council on Medical Education and its section on Family and General Practice failed to take the lead in these efforts. Now family practice programs, practically non-existent before, have burst out into the open. Specialty status is being sought by the establishment of a Board of Family Practice. The first board certification examination in 1970 was passed by 1704 of the 2000 who took it. Today an applicant is required to complete a three year residency in family practice. These eligibility criteria may prove impractical. Such standards may lead to two classes of family practitioners, those board certified and those not certified. This polarization will confront us with the same problem. Progress is evident in that eight schools now have full time departments of family practice and 40 other schools are in the planning stage. There are now 46 approved residencies with 290 residents in training. With the exception of some surgery and obstetrics, how different are these from the residency in Internal Medicine? Would not most of these residents prefer certification in Internal Medicine when they are finished?

Conclusion

How can we meet our urgent immediate objective to provide more and better family physicians for New Jersey?

1. Consideration should be given to return to the two year premedical program by elimi-

nating less pertinent courses.

2. Contract and modify the present four year medical course to three years by shortening the vacation periods.

3. Plan for the completion of the medical college at New Brunswick and graduate 200 students a year in each of the two medical schools by 1975.

4. Establish two divisions of Family Practice now at the New Jersey College of Medicine headed and staffed by experienced general practitioners chosen for their enthusiasm and ability to teach. Didactic lectures should be given at the college and practical instruction provided at the outpatient departments of affiliated hospitals.

5. For those already in family practice the New Jersey College of Medicine, as a state institution, should assume responsibility for organizing and supervising refresher courses for two purposes. The first is to qualify practitioners for Board certification in family practice, the second is aimed at improving the professional status of those practitioners who simply desire to keep abreast and are not interested in certification.

6. Several hospitals offer refresher courses. They would be better attended if given at night, twice a week for periods of three months at the East Orange Veterans Administration Hospital, where facilities for didactic courses are superb. These courses should provide credit toward eligibility for board certification.

7. Each affiliated hospital should include a section of family practitioners to make ward rounds and attend medical outpatient clinics. Record of attendance should be forwarded to the medical college administrative office. An additional one hundred hour credits would be added.

8. Grants to defray the expense to provide for this continuing education program should be provided by the government through the

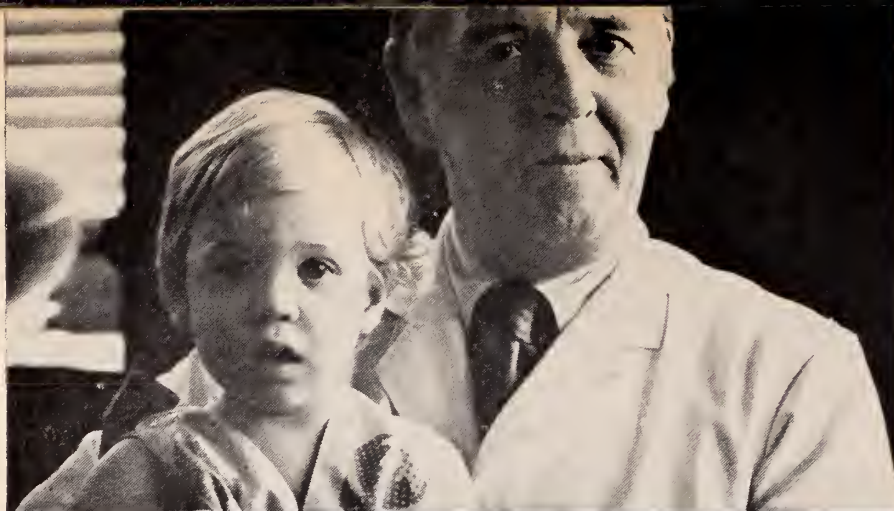
department of Health, Education, and Welfare. The AMA could serve a greater purpose by contributing from its research fund to provide for these courses.

9. Family practice must be made more attractive by improving its prestige, providing easy access to reasonable laboratory facilities, and encouraging dual or partnership practice. Solo practice is difficult, too time consuming and demanding. Sharing a practice permits enjoyment of a rewarding life of good medical service spiced with adequate leisure to pursue hobbies, social and public service, and continuing medical education.

Instead of facing up to the problem of providing more and better family doctors, it has been proposed to have a shortcut and stop-gap solution by creating a new corps of licensed medical assistants. Where and by whom will they be taught? *This would be a blunder which would be regretted and once started would be difficult to remove.* It would create serious problems in malpractice liability, extending the doctrine of *respondet superior* so that physicians would be liable for the negligence of the assistant whom they soon could neither control nor correct. We already have enough people entering practice by the backdoor. There are optometrists who don't mind being considered ophthalmologists, x-ray technicians who let you think they are roentgenologists, and psychologists confuse the public with their free use of the "doctor" title. Licensing a new group of "medical assistants" will simply invite one more bevy of invaders of medicine. The well meaning but crudely trained *feldsher* filled a need in the primitive back country of Eastern Europe at the turn of the century. We need not revive him now. We must not lose sight of the fact that this would be an added financial cost to medical insurance programs.

The proposed changes will provide more and better family physicians but will require foresight, boldness, and initiative on the part of the people who have the power, ability, and responsibility to solve this problem.

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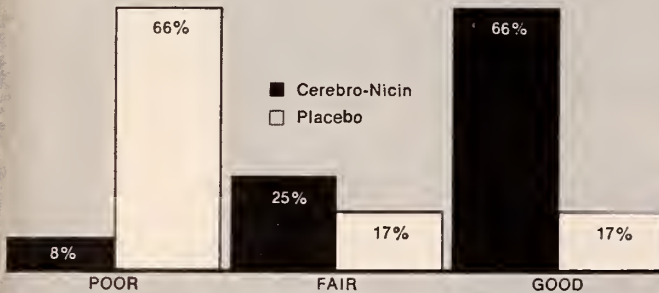


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References: 1. Montissano, P. and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12 69, 1966. 2. Berlin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5 67, 1964. 3. Titt, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25 6, 1962. 4. Helman, L., Bradlow, H. L., Zamest, B., Pakashima, D. K., and Gallagher, T. F. Thyroid-androgen interaction and the hypohyostreemic effect of androgen. J Clin Endoc 19 936, 1959. 5. Faris, E. J., and Cullen, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79 653, 1958. 6. Bell, A., and Farrar, S. E. United States Dispensary, Inc. 7. Lippincott, Philadelphia 1955, p. 1432. 8. Warshaw, L. P. Sexual Impotence in the Male Thomas, Springfield, Ill., 1959, pp 79-99.

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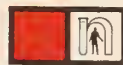
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The control of hypertension and heart disease are found to be major factors in the prevention of stroke.

Medical Problems In Stroke Patients*

**Edward S. Cooper, M.D. and
James W. West, M.D./Philadelphia**

For generations, stroke was relegated to the back of the wards, the back of the textbooks, and the back of the clinician's mind. This was true because completed stroke was an absolutely devastating illness and the physician seemed so incapable of altering its course. Today, we know so much more about stroke and its natural history. We know that many, if not most, completed strokes are preceded by transient ischemic attacks. Hypertension plays an important role in the genesis of stroke, a more important role than it plays in myocardial infarction. The parts played by diabetes mellitus, hyperlipidemia, heart failure, and atrial fibrillation have yet to be worked out. Many systemic disorders precipitate stroke in patients with cerebral atherosclerosis. Let us now refer broadly and briefly to the medical problems and management in stroke patients and review in greater detail certain areas which have been of special interest to our section of the Philadelphia General Hospital Stroke Research Center during the past few years.

Treatment of Initial Stroke

The treatment of acute stroke extends beyond the hospital stay. Special attention must be given to the patients' disability *after* discharge from the hospital. This involves physiotherapy, rehabilitation, emotional and psychological support, plus family education. An intimate knowledge of the community services which are available to the patient is especially helpful at this time. A Joint Committee for Stroke Facilities has been formed to assess the

quality of care available in our hospitals and communities for the stroke patient, and to establish guidelines and specify resources needed for the optimum diagnosis, treatment, and prevention of stroke. This committee, under the sponsorship of the American Neurological Association, is funded by our national government, and is composed of representatives from the voluntary and public agencies which have a significant interest in the stroke problem. The report of this committee should be available within two years.

TABLE I

Intermediate and Long-Term Care

- I. Medical Problems and Management
 - A. Treatment of initial stroke
 - B. Prevention of future strokes
 - 1. Transient ischemic attacks (TIA)
 - a. Close followup—TIA's
 - b. Surgery
 - c. Anticoagulant therapy
 - d. Special instructions
 - e. Adequate treatment of cardiac and other conditions
 - 2. Completed Stroke
 - a. Watch increasing TIA's
 - b. Anticoagulation to prevent embolism
 - c. Antihypertensive therapy
 - d. Cardiac surgery
 - e. Miscellaneous measures for underlying diseases—antibiotics, cardiac drugs, steroids, etc.
 - C. Close general medical followup, with treatment of complicating medical diseases

Prevention of Future Strokes

(1) *Transient Ischemic Attacks (TIA)* are usually defined as episodes of localized neurologic

* Read before the Section on Medicine, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 18, 1970. This work is from the Stroke Research Center and Department of Medicine, Philadelphia General Hospital and the University of Pennsylvania School of Medicine, Philadelphia. Supported by U.S. Public Health Grant #06520.

deficits caused by cerebrovascular insufficiency which last 24 hours or less, leaving no fixed deficit. The measures used for the prevention of TIA's differ in many respects from those used for completed stroke, though there is much overlapping. Cerebrovascular surgery is not ordinarily recommended for completed stroke except under very special circumstances such as subacute or chronic intracerebral hematoma, cerebral aneurysms, and so forth. The National Cooperative Study on Extracranial Vascular Occlusion has shown that surgery is beneficial for patients who have TIA's and carotid stenosis with or without contralateral carotid disease. Anticoagulant therapy is worthwhile in patients with TIA's when surgery is not indicated and when there is no contraindication to anticoagulant therapy, provided cerebral angiography is available. Special instructions regarding sudden and drastic head turning, measures to prevent postural hypotension, hypoglycemia, hyponatremia, polycythemia, and so on, are important in certain patients. The prevention and early detection of cardiac arrhythmias and congestive heart failure are of obvious importance.

(2) *Completed Stroke* is our next problem. Increased frequency of transient ischemic attacks (TIA) is often a premonitory sign of impending completed stroke. This deserves careful attention. Anticoagulation and cerebrovascular surgery are seldom used for completed stroke except under the special circumstances previously mentioned. Anticoagulant therapy is used to prevent additional cerebral embolism from cardiac sources under certain circumstances. Antihypertensive therapy is definitely indicated when severe hypertension has accompanied the stroke. It is undecided whether it is beneficial to treat mild to moderate hypertension in stroke patients. Heart surgery, such as mitral commissurotomy for mitral stenosis (and cerebral embolism), is occasionally necessary in stroke patients. In addition, stroke is occasionally caused by emboli associated with bacterial endocarditis, vascular occlusion in collagen disease, and so forth, requiring antibiotics, steroids, and other measures.

Close general medical follow-up, with treatment of complicating medical diseases is one of our concerns. Note Table II which lists some of the complicating medical diseases which have special significance in stroke patients. This significance varies from possible underlying importance in etiology (hyperlipidemia, syphilis, polycythemia, hyperproteinemia), potential treatment complications (peptic ulcer, diabetes mellitus), frequency of the associated disease (arthritis, angina pectoris), and prognosis (cancer, pulmonary disease, general deterioration).

TABLE II

Complicating Diseases with Special Significance in Stroke Patients

1. Obesity and smoking habits
2. Hyperlipidemia
3. Diabetes mellitus, hypothyroidism, other endocrine disturbances
4. Arthritis, pulmonary disease, syphilis, peptic ulcer, cancer
5. Angina pectoris and other types of heart disease
6. Polycythemia (primary and secondary)
7. Multiple myeloma and other dysproteinemias
8. Visual defects, renal disease
9. Post-stroke depression and mental aberration
10. Seizure states, physical inactivity, general deterioration

Stroke and Hypertension

Fifty to eighty per cent of all cases of stroke are estimated to have coexisting hypertension. Severe hypertension can produce stroke, both hemorrhagic and non-hemorrhagic. It has been established by Pierson and Hoobler¹, Marshall,² and Hamilton and his group³ that patients with severe hypertension are less likely to have a stroke if their blood pressure is treated. Prevention would be facilitated and of tremendous public health significance if strokes are caused by hypertension. This is because hypertension can now be successfully treated in almost all patients. Evidence suggests that acute hypertension may cause stroke by inducing cerebral arteriolar constriction and increasing cerebral vascular resistance or by causing rupture of microaneurysms, leading to a cerebrovascular syndrome. On the other hand, many feel that reduction of blood pressure in the face of arteriosclerotic cerebrovascular disease may induce cerebral thrombosis.

For many years it was felt that non-embolic cerebral infarction was simply the end stage of a progressive process of atherosclerosis of the extracranial or intracranial vessels with final thrombosis and obstruction to blood supply. Transient ischemic episodes were thought to be caused by transient falls in pressure and blood flow in critical areas of the brain. The treatment of hypertension, under this scheme, could reduce the occurrence of non-embolic cerebral infarction only by decelerating the rate of cerebral atherosclerosis. Transient ischemic attacks and cerebral infarction were always a danger when blood pressure was lowered.

Cerebral hemorrhage would, under this concept, be related to high levels of blood pressure and rupture of cerebral vessels, though it was realized that the ordinary levels of intraluminal pressure alone could not cause rupture of a blood vessel. Nevertheless, it was fully accepted, and justifiably so, that reduction in blood pressure would lower the incidence of intracerebral hemorrhage. However, we may need a new look at this because:

a. In many patients with non-embolic cerebral infarction, obstruction of cerebral vessels by atherosclerosis and thrombosis cannot be demonstrated.

b. Many non-hemorrhagic strokes seem to be produced by acute rises in blood pressure.

c. Pierson and Hoobler,¹ Marshall,² and Hamilton³ have all demonstrated a lowering of incidence of cerebral infarction when severe hypertension is treated.

d. In patients with transient ischemic attacks, lowering of blood pressure has also resulted in fewer TIA's as observed by Marshall.² Abrupt reduction in blood pressure did not always produce an episode resembling a transient ischemic attack. Despite considerable hypotension, only 17 of 36 patients developed symptoms suggestive of the previous attacks. As a matter of fact, Meyer⁴ noted an increase in cerebral perfusion on several occasions when blood pressure was lowered in such patients.

e. It is a common observation that patients whose blood pressure is adequately treated seldom develop stroke.

f. Russell⁵ recently reviewed and confirmed the old observation of Charcot and Bouchard⁶ that in many hypertensive patients with stroke, microaneurysms of the cerebral arteries may be found. He has reported their presence in 94 per cent of patients with diastolic pressure over 110 and only 26 per cent of normals. Thus, some strokes in such patients may actually be small leaks (hemorrhages) from these aneurysms. Russell⁵ has also presented some evidence that these

microaneurysms pass through various stages from a thin-walled lesion, susceptible to rupture, to a stage susceptible to thrombosis. The latter might lead to a small non-hemorrhagic stroke.

g. Byron⁷ has studied the cerebral vessels in experimental hypertension in rats. With the onset of hypertension, there is produced an exaggerated vasoconstriction in some focal areas of the rat brain, an exaggerated Bayliss reflex. Distal capillary anoxia then occurs with a resultant change in capillary permeability and diapedesis of red cells into brain tissue. The process would eventually resolve, leaving behind only a localized area of cerebral atrophy as the only sign of the hypertensive vascular insult. This is thought to mimic the process in the retinae of patients with severe hypertension.

These points are mainly applicable to patients with severe hypertension, i.e., in patients with diastolic blood pressures of 120 or above. Information has to be gathered about the benefits to be gained by lowering the blood pressure of patients with previous stroke whose baseline diastolic pressures are 90 to 115. Hoobler⁸ believes that lowering blood pressure in such patients will lower the incidence of stroke. A National Cooperative Study⁸ has been set up to test this hypothesis. The participating institutions are as listed on Table III. The study is carefully organized and monitored and is a double blind study using placebo and Enduronyl Forte®. The study will be composed of 350 to 500 randomized patients who have no contraindication to lowering or not lowering blood pressure. It may take five years before the final answer is in. The project is already in its third year.

TABLE III

*National Stroke-Hypertension Stroke Study
Central Registry: University of Michigan*

1. Wayne State University
2. Emory University
3. Bowman-Gray School of Medicine
4. Philadelphia General Hospital
5. University of Mississippi
6. Medical College of Georgia
7. Medical College of Virginia
8. University of Tennessee
9. University of Minnesota
10. University of Maryland

Heart Complications in Patients with Stroke and Their Effect Upon Prognosis

The observation that patients who die with stroke do not always have extensive brain damage suggests the importance of extra-

cerebral complications which may markedly influence the prognosis of patients with cerebrovascular accidents.

Clinicians frequently encounter heart problems when treating patients with stroke. These heart disorders frequently precede the onset of the acute apoplexy. In certain patients, they may actually precipitate the stroke.

We saw cardiac complications in 74 consecutive stroke patients admitted to the Philadelphia General Hospital. It becomes obvious that great attention should be given to the

heart during management of patients with stroke and in formulation of measures for the prevention of stroke in patients with cerebral atherosclerosis.

In Tables IV and V are listed the factors found in our stroke patients which correlate most closely with prognosis. Note that the presence of both heart failure and cardiac arrhythmias adversely affected prognosis, as did also Cheyne-Stokes respiration, level of consciousness and grade of motor paralysis. A large proportion of the patients with cardiac arrhythmia had merely frequent auricular or

TABLE IV
Relation Between Cardiovascular Assessment and Fatality

		No. of Patients	Per cent Fatality	chi Square
History of Heart Failure	Grade 0	39	48.7	
	1	13	69.2	9.06*
	2	11	81.8	8.80
	3	11	90.9	
Clinically assessed degree of heart failure	0	39	48.7	8.63*
	1 (Mild)	14	71.4	8.12†
	2 (Moderate)	12	83.3	
	3 (Severe)	9	88.9	
Venous pressure, mm. H ₂ O	<100	37	62.1	
	100-109	9	33.3	
	110-119	5	40.0	
	120-139	6	83.3	8.38*
	140-180	10	82.4	8.08†
	>180	7		
Digitalis therapy	Not started	46	50.0	
	Started	11	81.8	9.71†
	Continued	17	88.2	
Cardiac arrhythmias	Present	27	85.2	
	Absent	46	50.0	8.85†
	ECG not done	1		

* Significant at the 5% level (Chi-square test)

† Significant at the 1% level

TABLE V
Relation Between Neurologic Condition at Admission and Fatality

		No. of Patients	Per cent Fatality	chi Square
Cheyne-Stokes	Present	23	82.6	
	Absent	51	54.9	5.26*
Level of consciousness	0 (Alert)	12	16.7	
	1 (Obtunded)	27	51.8	22.53†
	2 (Stupor)	22	86.3	
	3 (Coma)	13	92.3	
Grade of motor paralysis	0	1	28.6	
	1	6		
	2	52	61.5	7.25*
	3	12	86.6	5.83*

* Significant at the 5% level

† Significant at the 1% level

ventricular premature contractions, but ten of the 74 patients had atrial fibrillation. Continuous cardiac monitoring of stroke patients in a Stroke Intensive Care Unit will uncover additional patients with cardiac arrhythmias, as in coronary care units.

Because of the frequency of cardiac abnormalities in patients with stroke, the Stroke Research Center at the Philadelphia General Hospital was established to obtain physiologic information in order to clarify the relationship between cardiac function and cerebral circulation. Cardiac hemodynamic studies, including cardiac catheterization, are performed on selected stroke patients who have various cardiovascular disorders, and then correlated with cerebral blood flow (regional and total), cerebral angiography, clinical findings, and with autopsy findings in those patients who succumb to stroke. The cardiac hemodynamic parameters which are determined include those listed in Table VI. The findings from the correlated studies as described are of considerable interest and clinical importance, and are to be reported elsewhere.⁹

TABLE VI

Cardiohemodynamic Studies

1. Systemic arterial blood pressure
2. Venous pressure
3. Right atrial pressure
4. Right ventricular pressure
5. Pulmonary arterial pressure
6. Pulmonary wedge pressure
7. Heart rate
8. Cardiac output (Fick and dye)
9. Cardiac work
10. Total peripheral resistance
11. Metabolic determinations

Correlate with clinical findings, cerebral blood flow, cerebral angiography, and neuropathological findings

Concluding Remarks

Stroke is a clinical syndrome presenting with dramatic neurologic signs. It is mainly a neurologic disease which requires a physician with an appreciation and understanding of neurology. This physician may be either a neurologist, a general practitioner or an internist with special interest in cerebrovascular

disease. Simply because of the shortage of neurologists and the setting under which stroke occurs, most stroke patients are seen first and cared for by general practitioners or internists. In my opinion, however, *all* stroke patients should at least be seen in consultation by neurologists, who should be involved in the management of the patient as far as their time and interest permit. This is especially true during the period of diagnostic workup and short-term and long-term planning. The actual week to week long-term management, except in certain large institutions, is usually carried out by the general physician or internist. This is probably wise because of the varied and complex medical problems frequently found in stroke patients. Certainly the prevention of stroke should be our ultimate aim, and prevention involves mainly the control of hypertension, atherosclerosis and heart disease, with a broad medical approach. In my experience, the neurologist can identify transient ischemic cerebral episodes, which often presage completed stroke, better than the general physician and internist. The management of stroke should be a joint team venture.

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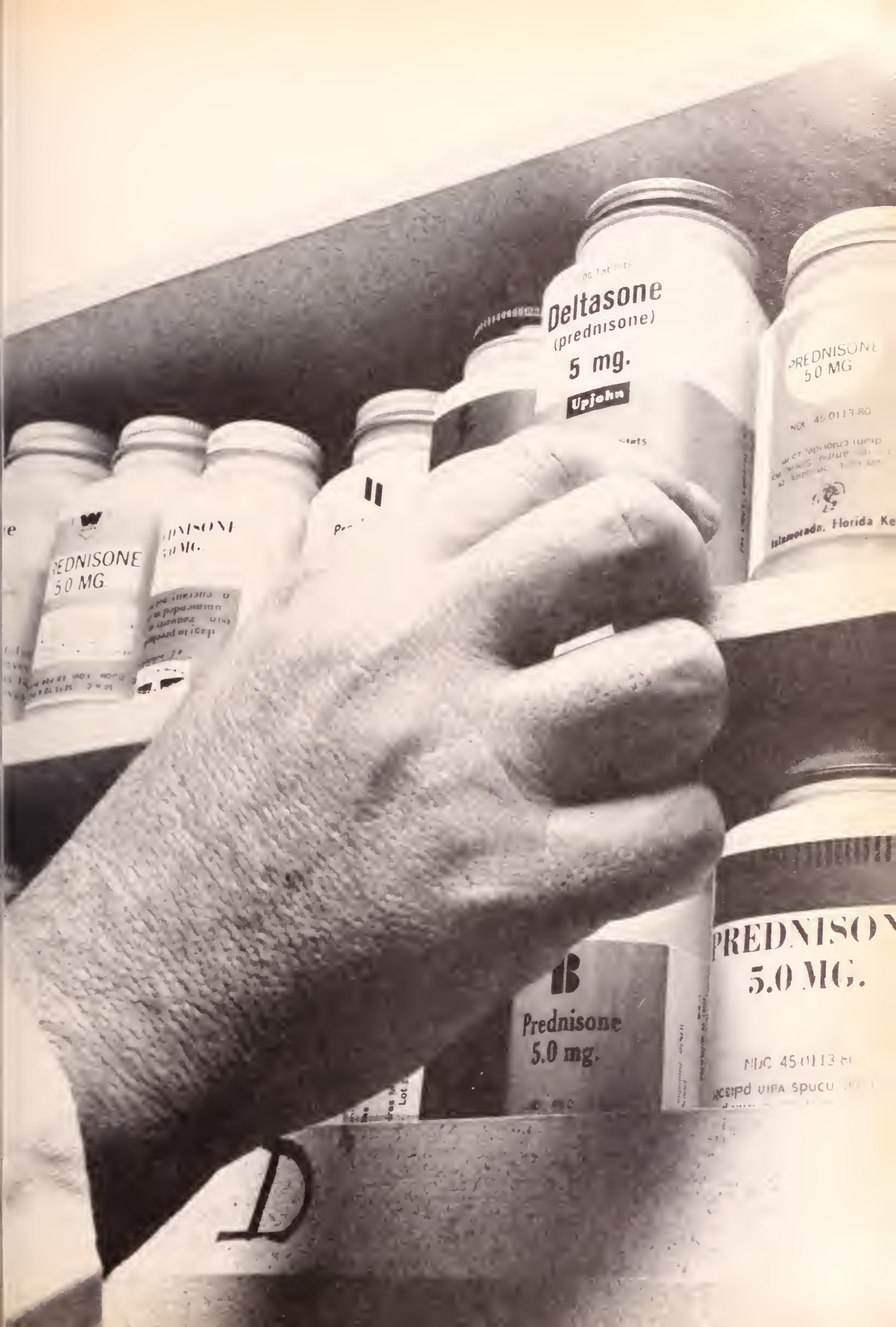
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Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccination, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance

doses of Deltasone (prednisone), however, keep this in mind and perform periodic serum potassium determination in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9- α -fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoid during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis an ulcer regimen and antacid are highly recommended. Take X-ray in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that have less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance, electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fracture; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

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One of the automobile's gifts to humanity is traumatic rupture of the aorta. Here is a report of nine cases in three months in one county.

Rupture Of The Aorta In Medical Examiner Cases*

Report of Nine Cases and a Review of the Literature

**William C. Wilentz, M.D., et al./
Perth Amboy**

Rupture of the aorta may result from severe trauma and is being seen more frequently as a result of automobile accidents. Steering wheel injuries account for a high proportion of these incidents. Hopefully, safety equipment now mandatory by law, such as collapsible steering columns, will lessen the death toll from this cause. All chest injuries must be carefully evaluated with adequate follow-up and immediate heroic surgical intervention undertaken in cases where aortic rupture is suspected. In 1947, Strassman⁷ reported the largest series of traumatic rupture of the aorta: 72 cases over a six year period. Other publications contained smaller numbers of cases, e.g. Jaffe and Steinberg⁸—ten cases; five of which occurred in flying accidents; McDonald and Campbell⁹—two cases; Molnar and Pace¹—seven cases; Clark, *et al.*³—five cases; and Blank²—two cases.

This condition was uncommon in our experience until recently when nine cases were encountered in a 3 month period.

Case 1 was a 43 year old male, the driver of a car involved in an accident. He was pronounced dead at the scene. Postmortem examination revealed multiple rib fractures, rupture of the liver, hemothorax and hemoperitoneum, and rupture of the aorta at the isthmus.

Case 2 was a 27 year old male, also the driver

of a car involved in an accident, who was pronounced dead at the scene of the accident. Postmortem examination revealed multiple rib fractures, hemothorax, and a ruptured aorta at the isthmus.

Case 3 was a 57 year old male passenger in an auto accident. He was dead on arrival at a hospital. Postmortem examination revealed multiple rib fractures, hemothorax and hemoperitoneum, fractured legs, and rupture of the aorta at the isthmus.

Case 4 was a 32 year old female driver of a car who had been admitted to a hospital with multiple rib fractures (right 2nd and 3rd and left 3rd), a fractured right femur, and a superficial skin laceration of the left knee. She died four hours after admission. Postmortem examination revealed a hemopericardium due to a 1.5 cm. laceration of the ascending aorta.

Case 5 was a 50 year old male driver whose car struck a pole. He died in the hospital shortly after admission while x-rays were being taken. Postmortem examination revealed multiple right rib fractures, interstitial emphysema of the anterior chest wall, rupture of the liver and right kidney, and rupture of the aorta. The rupture was transverse at the

* This work is from the Perth Amboy General Hospital and from the Middlesex County Medical Examiner's Office where Dr. Wilentz is chief medical examiner. The other authors are Marvin Shuster, M.D., deputy medical examiner; Stanley M. Becker, M.D., deputy medical examiner; and Kalish B. Sharma, M.D., resident in pathology at the Perth Amboy General Hospital.

isthmus (below the left subclavian artery) and measured 1.6 cm. in length. Hemothorax and hemoperitoneum were also present.

Case 6 was a 63 year old male truck driver who was injured in an altercation with hijackers. Three hours after the fight he experienced chest pain and died two hours and fifteen minutes after admission to the hospital. Postmortem examination revealed a partial rupture of the aorta 1.8 cm. above the aortic cusps, transverse, and involving 80 per cent of the circumference of the aorta through an opening measuring 2 centimeters in length. This resulted in a dissection between the media and adventitia.

Case 7 was a 49 year old male pedestrian who had been hit by an automobile. He was dead on arrival at a hospital. Postmortem examination revealed multiple rib fractures on the right and left side, lacerations of the liver and spleen, hemothorax, and a transverse rupture of the aorta at the isthmus.

Case 8 was dead on arrival at the hospital following a head-on collision with another automobile. He was a passenger in the right front seat. The only visible external injuries were minor abrasions of forehead, but he suffered extensive internal injuries including multiple rib fractures; hemoperitoneum, hemothorax, bilateral; and lacerated liver, spleen and left kidney. The aorta was completely transected 2.5 cm. below the origin of the left subclavian artery.

Case 9 was admitted, dead on arrival, following a collision. He had rib fractures, hemothorax, transected aorta at the isthmus, and a ruptured liver.

Eight of our nine victims suffered rupture of the aorta, obviously due to trauma from automobile accidents. Five of these seven were drivers of automobiles involved in accidents with other cars or a pole, while two were passengers and another was a pedestrian. Associated with the rupture in these cases which was complete through all layers of the aorta and was distal to the origin of the left

subclavian artery, there were hemothorax, hemopericardium, hemoperitoneum, and rib fractures.

Case 6 is less clearcut as far as the etiologic role of trauma is concerned. His trauma was from an altercation rather than from an automobile injury and he did not have rib fractures, hemothorax, hemopericardium or hemoperitoneum. The site of this rupture was 1.8 centimeters above the aortic valve cusps rather than distal to the left subclavian artery and blood dissected proximally and distally between the media and adventitia of the aorta. A likely explanation of these findings is that this patient had a weakness of his aorta due to atherosclerosis and degeneration of elastic fibers, and a minimal amount of trauma, such as a blow to the chest, was responsible for the partial rupture and dissection.

Three of the nine cases (4, 5, and 6) survived the rupture and were admitted to hospitals. They died however, within four hours of admission. X-rays of the chest (figure 1) in



Figure 1—X-ray of chest showing enlarged mediastinal shadow

case 5 revealed fractured ribs and widening of the mediastinum, but the patient expired before any further diagnostic or therapeutic procedures could be performed.

Although all of these nine cases were fatal, traumatic rupture of the aorta is not necessarily a fatal injury according to Stoney *et al.*¹⁰ They estimate that more than 80 per cent die before reaching a hospital and an-



Figure 2—Specimen showing transverse tear of aorta at level of left subclavian artery



Figure 3—Aorta with complete transection below origin of subclavian artery



Figure 4—Arrows point to torn aorta below Botallo's ligament



Figure 5—Transverse rupture of aorta with dissection is seen above aortic valve cusps

other 10 per cent to 15 per cent in the next two to three weeks. The survivors include those patients who develop a stable aneurysm. Cooley¹⁰ reported surgical repair of this condition in 60 consecutive patients 2 to 24 months following injury without mortality. The most frequent site of rupture in several series (including ours) was at the isthmus of the aorta just below the origin of the left subclavian artery at the insertion of Botallo's

ligament, (50 to 80 per cent) (Figures 2, 3, and 4). Approximately 20 per cent also occur just above the aorta cusps, the most frequent site of spontaneous rupture (Figure 5). Almost all cases showed a transverse rupture, complete in approximately 90 per cent, and partial with dissection in the remaining 10 per cent. A large majority (86 per cent) also showed fractures of ribs alone or together with the sternum and vertebrae.

According to Molnar and Pace¹ a sudden deceleration of the body and compression of the chest producing an intraluminal pressure of more than 2000 millimeters of mercury, results in rupture of the aorta. This amount of force is only produced by severe injury such as that which results from auto accidents, plane crashes, or falls from heights. The relative fixation of the isthmus by the left subclavian artery and the mobility of the descending arch below is responsible for the propensity for rupture at this site.

The cars involved in these accidents included a 1956 Buick, a 1962 Pontiac and Buick, a 1965 Buick, a 1966 Pontiac station wagon, and a 1968 Plymouth station wagon. In only one of these cars (the Plymouth station wagon) was the driver wearing a seat belt. It was of the waist type rather than the shoulder type. No car had a collapsible steering wheel.

Early suspicion, recognition, and treatment offer the only means of survival. Multiple rib fractures in patients in auto accidents or other trauma should arouse the suspicion of a ruptured aorta. Sanborn *et al.*¹² mention three signs on plain chest films that point to aortic rupture: abnormalities of the aortic knob, mediastinal hematomas, and hemothorax. A diagnostic pleural tap yielding blood is further evidence. Aortography is mandatory when the plain films suggest mediastinal bleeding. Demonstration of a rupture by aortography should be followed by immediate chest surgery to repair the tear when possible. Many successful operative repairs have been reported.^{2, 10, 11}

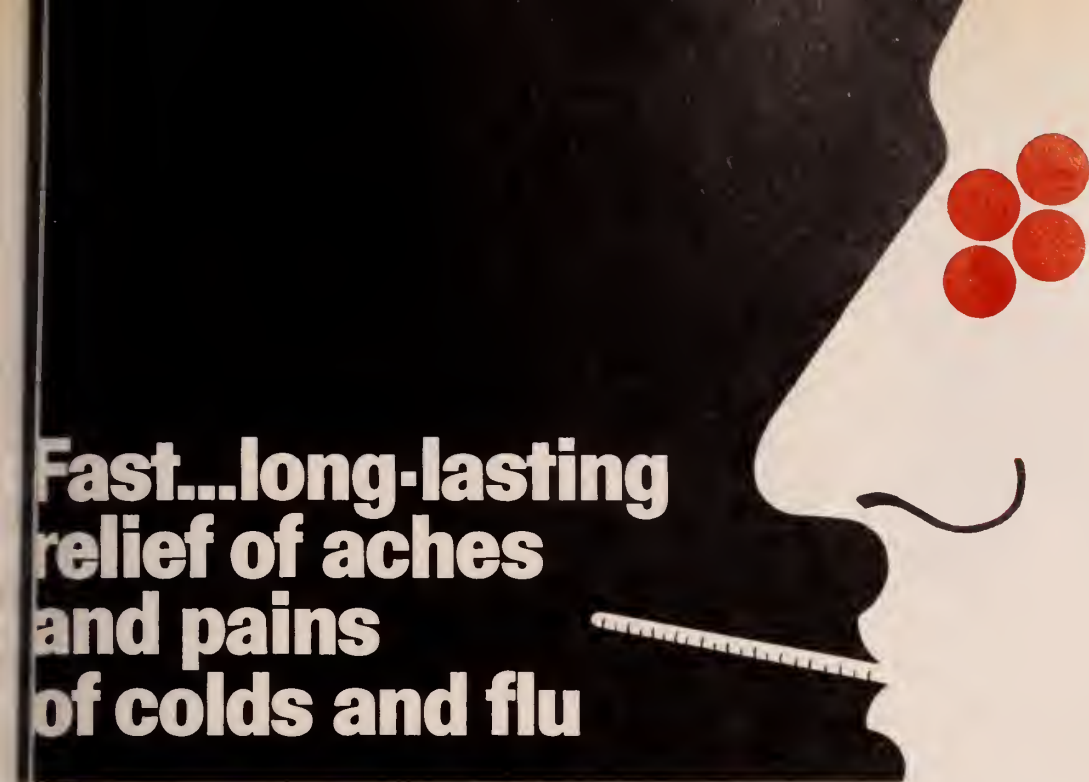
Summary

Nine cases of ruptured aorta occurring in a recent 3 month period in a medical examiner's practice have been reported. Past experience had shown this condition to be infrequent. The majority of these occurred in auto accidents (driver, passenger, or pedestrian) while one was associated with an altercation. Eight of the nine had fractured ribs, hemothorax, hemopericardium or hemoperitoneum, and the site of the rupture was at the isthmus. Automobile manufacturers have done little (until recently) in the design of their cars to prevent this almost uniformly fatal type of injury. Waist type safety belts alone do not seem adequate to prevent this kind of severe injury. Minimal safety measures should include shoulder type safety belts and collapsible steering wheels. The proposed system of air bags to restrain forward motion of car occupants in automobile accidents should further reduce chest injuries and aortic ruptures. Early suspicion of this condition in auto accident victims with fractured ribs, early diagnosis by chest roentgenograms and aortography, and early operative repair offer these patients a chance for survival.

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Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



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Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

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1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinistest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infection may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 50 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening condition has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber stoppered; 1 Gm., 10-ml. size, rubber stoppered.

[08216]

Additional information
available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

In treating monilia infection, the doctor should consider the contraceptive method, if any, used by the patient.

Gynecologic Moniliasis

Incidence With Various Contraceptive Methods

Allan Lazar, M.D./Teaneck

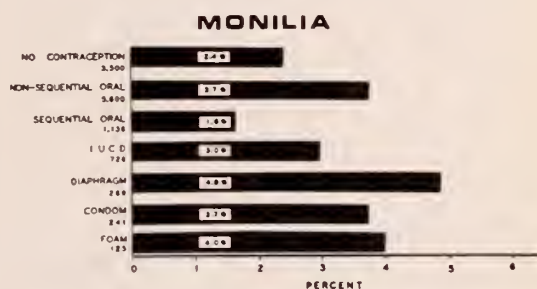
Cytology smears were received from physicians in private practice in the New York-New Jersey metropolitan area, stained and examined by the acridine orange fluorescence technic,¹ and data recorded in terms of cellular abnormality, flora of micro-organisms, density of inflammatory cells, and hormonal strength. Information on history, medication, type of contraception, physical findings, and diagnostic impressions were coded on punched cards for tabulation.

Included in this study, on a random basis, are 11,197 private patients, on whom the physicians provided sufficient data and who met the following criteria: married, under age 50; not pregnant, post-partum, nor menopausal; not diabetic; not using any kind of medication (except for the possibility of oral contraception); having never had a major gynecologic surgical procedure at any time, nor a minor gynecologic surgical procedure in the past year. The cases were received between January 1966 and November 1968.

Material for examination was collected with a cotton swab, rolled onto glass slides and allowed to air-dry.² The cytology samples were stained by the acridine orange ten-second method of Riva and Turner³ and examined by the fluorescence technic. After staining with acridine orange³ the slide was illuminated by a 100 watt mercury vapor lamp⁴ in front of which was a Corning 5113 filter.⁵ The nuclei of squamous cells, endometrial cells, and inflammatory cells fluoresce greenish-yellow. The cytoplasm of these cells also fluoresces greenish-yellow but not as brightly.

Bacteria, trichomonads, monilia, and fungal spores fluoresce bright red. A Wratten G barrier filter (Kodak Company) in the eyepieces of the microscope stops all light except

Chart I



Relationship of gynecologic moniliasis to contraceptive methods. All are private patients. None are pregnant, post-partum, or menopausal. None using any drugs or hormones (except for the possibility of oral contraceptives). Figures under the name of the contraceptive method indicates the total number of women in the category.

that which emanates from the cells and results in a black background against which the cells stand out clearly.¹

Moniliasis

Monilia infection was reported on all smears containing the hyphae of monilia, regardless of the density of inflammatory response.

Among the types of contraception, non-sequential oral contraception includes all contraceptives in which the same combination of drugs is taken throughout the 21 to 25-day cycle regimen. (Orthonovum®, Enovid®, Enovid-E®, Norinyl®, Provest®, Ovulen®, Norlestrin®, and Ovral®). The sequential oral group includes contraceptives in which one drug is taken during the first half of the

cycle, and a different drug (or a combination of drugs) is taken during the second half of the cycle-regimen of 21 to 25 days. (C-Quens[®], Oracon[®], Orthonovum SQ[®]). Women with an intrauterine contraceptive device (IUCD) were using no additional means of contraception. The group using foam used this alone with no additional medication or device.

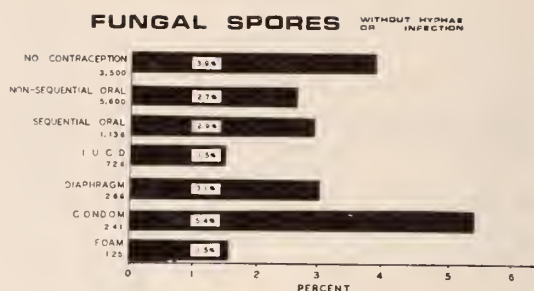
Considering the no contraception group as the "control," the incidence of monilia infection is increased to some extent in all contraceptive groups except the sequential oral group. (See Chart I) The incidence is greatly increased in the group using the diaphragm; moderately increased in the groups using foam only, condoms, and non-sequential orals; and slightly increased in the group using IUCD.

Fungal Spores

Patients with spores on cervico-vaginal smear, but no hyphae or significant inflammatory reaction, are reported in Chart II. The number of patients was 359 with hyphae and 356 with spores only. However, the distribution is quite different; only the group using condoms had a greater proportion of spores than the no contraception "control" group and the difference between these two groups is not significant.

The incidence of spores alone is about the same in the sequential and the non-sequential oral contraception groups, and the group using the diaphragm. The group using IUCDs had the lowest incidence of spores.

Chart II



Relationship of fungal spores to contraceptive methods. Vaginal smears with fungal spores present but no hyphae or significant inflammatory reaction. All are private patients. None are pregnant, post-partum, or menopausal. None using any drugs or hormones (except for the possibility of oral contraceptives). Figures under the name of the contraceptive method indicate the total number of women in the category.

Conclusion

The incidence of gynecologic monilia infection varies with different methods of contraception. This should be taken into consideration by the physician in treating the acute infection and also in preventing recurrence.

The author acknowledges the valuable assistance of Mr. Northrup and Mrs. Yanoff of the computer center of Fairleigh Dickinson University in the compilation of these data.

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1. Riva, H. L. and Turner, T. R.: *Obstetrics and Gynecology*, 20:451 (April 1962)
2. Bonime, Ralph G.: *Acta Cytologica*, 12:251 (June 1968) and *Obstetrics and Gynecology*, 27:783 (July 1966)
3. Hartmann-Leddon Company of Philadelphia
4. General Electric, H-100PSP 44-4
5. Nikon, Inc., Garden City, New York

986 Teaneck Road

205th Annual Meeting

May 15-18, 1971

Traditionally you had either infectious hepatitis or serum hepatitis, but not both. Here is a study which suggests that serum hepatitis may masquerade as (and be falsely labeled as) catarrhal jaundice.

New Concepts In Hepatitis*

**Manuel M. Villaverde, M.D. and
Jacyntho A. Da Silva, M.D./Woodbridge**

When we hear of hepatitis, we think first of infectious hepatitis or serum hepatitis, as differentiated since World War II. Infectious hepatitis corresponds to the old catarrhal jaundice and serum hepatitis, to post-transfusion or homologous serum jaundice. Two different viruses, virus A or IH, and virus B or SH, were accepted as responsible for each form of hepatitis. Liver changes are indistinguishable from one form to the other. It is frequently found as an overlapping symptomatology or an overlapping of anamnestic data that make the diagnosis of IH or SH also uncertain. For instance, when no source of contamination is known for actual SH cases, the diagnosis of IH is ordinarily made—and is surely wrong. There are reports of patients developing clinical hepatitis after being exposed to contact with patients positively contaminated with SH.

Laboratory tests are generally not specific for hepatitis, but for liver damage or, at most, for jaundiced serum: serum transaminases (SGOT and SGPT), thymol turbidity, cephalin flocculation, serum cholesterol (free and esters), serum bilirubin, and even prothrombin time and urobilinogen.

Recently, the detection of the hepatitis associated antigen (HAA), also known as Australia antigen, SH antigen, and hepatitis antigen, added an important milestone to the understanding of hepatitis.

Following transfusions, some precipitins develop in the blood, which react with specific serum lipoproteins (isoproteins), when both sera are placed on adjacent wells on a plate

(the one containing serum with the precipitin and the other containing the serum to be tested). The reading is done by finding a precipitin line that appears between both sera. The precipitins are supposed to be antibodies against serum lipoproteins, stain with sudan black are of low density and may present several different lipoprotein specificities. It is also known that reactor specificity is autosomal dominant.

One of the known isoprecipitins were found to be formed from the serum of an Australian native. A clear precipitin line was observed, but it stained better with azocarmine than with sudan black. The precipitin was called "Australia antigen," and was supposed to be different from lipoprotein precipitins because of the different staining and the different distribution among patients and world populations.

In populations considered to be normal (no history of hepatitis) the Australia antigen was found as follows: Taiwanese, 13 per cent; Australians, 6 per cent; and 4 per cent among Micronesians, Polynesians, Greeks, and Vietnamese. Also, it was found in 11 per cent of leukemia patients, and in 4 per cent of thalassemia patients. Its association with leukemia was noticed first, and only in later studies was found its more close relationship with hepatitis. The administration of hepatitis antigen may provoke clinical hepatitis with detectable antigen or without it, in some instances; and also detectable antigen may appear without evident symptomatology of clinical hepatitis. But it is to be noted

* From the Woodbridge State School Hospital, Woodbridge, New Jersey.

that inoculations have been positive even with undetectable amounts of antigen.

By immuno-fluorescence technics, the Australia antigen is found, but it only appears in liver cells.

The HAA (according to any nomenclature, either Australia antigen as well as SA antigen) is found in hepatitis, but only in those corresponding to serum hepatitis and *not* to infectious hepatitis, according to well controlled studies carried on during epidemics of hepatitis. It may be present in blood before the appearance of clinical symptomatology, and will remain present for long periods of time in only a half of the number of patients. The other half will present the antigen only transiently. A few cases diagnosed as suffering IH did present HAA in their blood, so they were true SH cases.

A number of mongoloids did present the antigen in their blood. After being exposed to the disease, the duration of positiveness of HAA in their blood did not differ from other patients. That these mongoloids were chronic cases of hepatitis would be assumed by their histologic liver changes and the elevated serum transaminases. The antigen appears in apparently healthy persons, without clinical hepatitis; but most probably they suffered from anicteric hepatitis. It is to be noted that 30 per cent of mongoloids in institutions will present HAA, and they are those in whom the disease tends to be chronic and anicteric. Recent findings show that HAA in blood will

persist for long periods of time (chronic disease) in patients with impaired immunological responsiveness, and only for short periods (acute disease) if there is a normal immunological responsiveness.

There are those¹ who prefer not to use the IH or SH terminology, feeling it is confusing at the present time.

The more important concepts derived from these studies are that epidemics of hepatitis may show, on clinical grounds, positive features of both IH and SH, but they may be only SH epidemics (HAA antigen present in blood); and that the joint use of tests for transaminase and HAA will help to detect earlier more cases of serum hepatitis.

Summary

There is strong support for the assumption that many cases clinically labeled as infectious hepatitis are true cases of serum hepatitis. The hepatitis associated antigen (HAA), also known as Australia antigen, SH antigen, or hepatitis antigen, has been proved to be present only in cases of serum hepatitis. This HAA will help, together with the tests for transaminases (SGOT and SGPT), for the earlier detection of cases of serum hepatitis.

Addendum: Of the 160 residents with the diagnosis of Down's Syndrome at Woodbridge State School Hospital, 55 were positive for Australia antigen (34.5%). These findings are in close agreement with previous publications on the incidence of Australia antigen among mongoloids.

¹Blumberg, B. S., *et al.*: *New England Journal of Medicine*, 283:349 (1970)

Woodbridge State School

Johnson Chair Of Surgery

Johnson and Johnson, Inc., of New Brunswick, has awarded half a million dollars to the New Jersey College of Medicine and Dentistry at Newark to endow a faculty chair of surgery. Benjamin J. Rush, Jr., M.D., Surgeon-in-Chief at Martland Hospital, has been named Professor and Chairman of the

Department of Surgery and will fill this chair. Dr. Rush heads a faculty of 25 in the Department of Surgery and also serves as consulting Surgeon at the Veterans Hospital in East Orange, at the Newark Beth Israel Medical Center, and at the St. Barnabas Medical Center in Livingston.

once-popular treatment for back pains
is to have the seventh son of a seventh son
stand on the patient's back.



The pain of earache was allegedly relieved
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For headache, a sovereign remedy was
to wear a snakeskin round one's head.



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Now that there's a greater therapeutic potential for treating Parkinson's disease and syndrome

...the information on these pages will be of practical interest to you

Larodopa® (levodopa) Roche : therapy that demands slow, individualized dosage titration

With the advent of new Larodopa (levodopa), there is now an agent that holds promise of relief of all the major symptoms of Parkinson's disease and syndrome—rigidity and akinesia as well as tremor.

However, as has been reported in the medical literature, levodopa demands slow, careful titration of dosage, and frequent patient monitoring. Adverse reactions may occur at any time, some serious enough to require dosage reduction or discontinuance of therapy. Thus, before prescribing, it is particularly important to refer to the following Important Therapeutic Considerations, the sections covering dosage and administration, and to the information on monitoring the patient (see prescribing information).*

Important Therapeutic Considerations

Larodopa (levodopa) is an unusual drug which must be administered with particular care. In view of its high incidence of adverse reactions, you will find the following therapeutic considerations for Larodopa important:

- (a) Larodopa is not curative and its mechanism of action is unknown, though postulated.
- (b) Long-term safety and efficacy for Larodopa have not been established.
- (c) Accurate diagnosis is imperative since there is no evidence that Larodopa is effective in neurological diseases other than Parkinson's disease and syndrome.
- (d) About one-third of patients or more will not experience clinical improvement on Larodopa, and virtually 100% of patients will experience side effects of some degree.
- (e) The dose of Larodopa producing maximal improvement with tolerated side effects must be *carefully titrated for the individual patient*.
- (f) Finally, there is no evidence that early treatment with Larodopa, while possibly controlling symptomatology, alters the course of the disease.



Photographs of patients treated with Larodopa by permission of the patients.

Guide to dosage and administration of Larodopa® (levodopa) Roche

Usual daily dosage—initially, 0.5 to 1 Gm daily (divided 2 or more doses with food).

Total daily dosage—increased gradually in increments of 0.125 to 0.75 Gm every 2 or 3 days, as tolerated.

Usual daily dose range—from 4 to 6 Gm given orally in 3 or more divided doses, with food.

Daily dosage should NOT exceed 8 Gm.

Optimal therapeutic dosage—usually reached in 6 to 8 weeks.

Establishing optimal dosage—must be determined and carefully titrated for the individual—gradually increase dosage until: (1) maximal response is seen, or (2) maximum recommended dosage is reached, or (3) side effects preclude further dosage increase, or require reduction or discontinuation of dosage.

Interrupted therapy—after brief interruption, dosage should again be adjusted gradually. (In many cases, the patient can be rapidly titrated to his previous therapeutic dosage. See "Precautions" section of Complete Prescribing Information.)

To underscore the extreme importance of careful dosage titration, the following week-by-week dosage pattern has been prepared, based on the assumption that the course of therapy is uninterrupted by any complications requiring a change in dosage. (Again, dosage must be reduced when intolerable side effects occur.)

Because it is absolutely imperative that Larodopa therapy be individualized to meet the particular needs of each patient, the following dosage schedule should be considered only a model.

Larodopa[®]

levodopa/Roche

Titration of Larodopa (levodopa) dosage in patient evaluated weekly

Intervals	0.25 Gm Tablets	0.5 Gm Tablets	Total Daily Dose
Week 1	½ tab (0.125 Gm) <i>q.i.d.</i> w/ food		0.5 Gm
Week 2	1 tab (0.25 Gm) <i>q.i.d.</i> w/ food		1.0 Gm
Week 3	1½ tab (0.375 Gm) <i>q.i.d.</i> w/ food		1.5 Gm
Week 4		1 tab (0.5 Gm) <i>q.i.d.</i> w/ food	2.0 Gm
Week 5		1½ tab (0.750 Gm) at breakfast and dinner. 1 tab (0.5 Gm) at lunch and bedtime	2.5 Gm
Week 6		1½ tab (0.750 Gm) <i>q.i.d.</i> w/ food	3.0 Gm
Week 7		2 tab (1.0 Gm) at breakfast and dinner. 1½ tab (0.750 Gm) at lunch and bedtime	3.5 Gm
Week 8		2 tab (1.0 Gm) <i>q.i.d.</i> w/ food	4.0 Gm

The daily maintenance dosage in the above example may be increased, decreased, or maintained at the 4 Gm level depending upon the point at which optimal therapeutic results are achieved.

Concurrent therapies: Larodopa (levodopa) may be used concomitantly with other antiparkinsonism drugs such as benztropine mesylate (Cogentin), trihexyphenidyl HCl (Artane) or procyclidine HCl (Kemadrin), but when more than one drug is used, the usual dose of each may have to be reduced.

Not to be given concomitantly: MAO inhibitors. Such agents must be discontinued two weeks prior to initiating Larodopa therapy.

Note of caution for patients who require vitamin supplementation: It has been reported that pyridoxine HCl (vitamin B₆) can rapidly reverse the antiparkinson effects of levodopa therapy.

A timetable for monitoring

While it cannot be emphasized too strongly that each patient on Larodopa must be treated as a totally *distinct* entity, the following are suggested as guidelines in the monitoring of such patients.

1. *For the first month, at least:* the average ambulatory outpatient should be seen and evaluated a minimum of *once a week*.
2. *During the second month:* patient evaluations can be extended to *every two weeks* (assuming no laboratory abnormalities or intolerable side effects have occurred).

3. *From the third through the sixth month:* the patient should be evaluated *once a month*.

4. *After six months on the appropriate maintenance dose:* with no significant adverse reactions or laboratory abnormalities, the patient should be seen at least *once every two months*.

5. *Finally, after one year on maintenance dosage:* evaluation should be made no less than *once every three months*.

Therapeutic response

A favorable response may often be seen within 10 days to several weeks. However, a patient should not be taken off a tolerable dose—even in the absence of a response—until six months have elapsed. This is because, in some instances, the response may come relatively late. Of course, any serious laboratory abnormalities or intolerable side effects automatically dictate discontinuance of therapy.

Lessening the side-effects problem

While it is generally advisable that levodopa be taken after meals, nausea and vomiting, two frequently occurring side effects of levodopa, can often be minimized by taking medication with foods. If nausea becomes intolerable, the dosage should be cut back in daily decrements equal to the most recent increments given the patient. This reduction is to be spaced over two- or three-day intervals. Conversely, as nausea subsides, the drug dosage should be slowly increased in like increments.

An important part of the routine monitoring procedure would be to determine any possible cardiovascular problems. If cardiac arrhythmias occur, Larodopa should be discontinued and other antiparkinson therapy instituted. With orthostatic hypotension a possibility, checking the patient's blood pressure (both supine and standing) is essential.

If choreiform movements appear, they usually occur when maximum therapeutic dosages are reached. To control such effects, reduce dosage by decrements of 0.5 Gm daily.

Flexible dosage: scored tablets of 0.25 Gm and 0.5 Gm help simplify dosage titration



Conveniently scored 0.25 and 0.5 Gm tablets make possible more precise titration. Should another dosage form be preferred, Larodopa is also supplied in capsule strengths of 0.25 and 0.5 Gm.

Before prescribing, please consult product information on next page. →

Larodopa® levodopa/Roche

*For the relief of symptoms associated with
Parkinson's disease and syndrome*

Before prescribing, please consult complete product information, a summary of which follows:

BECAUSE OF THE HIGH INCIDENCE OF ADVERSE REACTIONS AND THE NECESSITY FOR INDIVIDUALIZING THERAPY, THE PHYSICIAN SHOULD THOROUGHLY FAMILIARIZE HIMSELF WITH THE INFORMATION IN THE PACKAGE INSERT BEFORE INSTITUTING THERAPY WITH LARODOPA (LEVODOPA). ACCURATE DIAGNOSIS IS IMPERATIVE BECAUSE EVIDENCE IS LACKING THAT LARODOPA IS EFFECTIVE IN NEUROLOGICAL DISEASES OTHER THAN PARKINSON'S DISEASE AND SYNDROME.

ADEQUATE CLINICAL AND LABORATORY FACILITIES SHOULD BE AVAILABLE FOR PROPER MONITORING OF TREATMENT.

THE LONG-TERM SAFETY AND EFFICACY OF LARODOPA HAVE NOT BEEN ESTABLISHED.

Indications: For the treatment of Parkinson's disease and syndrome. Useful in relieving many of the symptoms, particularly rigidity and bradykinesia; frequently helpful in management of associated tremor, dysphagia, sialorrhea and postural instability.

Contraindications: In patients for whom a sympathomimetic amine is contraindicated; in patients receiving MAO inhibitors (the latter should be discontinued two weeks prior to initiating therapy with Larodopa); in patients with clinical or laboratory evidence of **uncompensated** endocrine, renal, hepatic, cardiovascular or pulmonary disease; with narrow angle glaucoma and blood dyscrasias; in patients with known hypersensitivity to levodopa.

Warnings: Long-term safety and efficacy not established. Administer with extreme caution to patients with bronchial asthma or emphysema who may require sympathomimetic drugs; to those with active peptic ulcer (in facilities equipped to treat gastrointestinal hemorrhage); in patients with psychoses or severe psychoneuroses. Initiate therapy with extreme caution and in proper treatment facility in patients with a history of myocardial infarction who have residual atrial, nodal or ventricular arrhythmias. Monitor all patients for development of mental changes, depression with suicidal tendencies, other serious antisocial behavior. Carefully consider concomitant administration of pyridoxine hydrochloride (vitamin B₆); oral doses of 10 to 25 mg have been reported to rapidly reverse the antiparkinson effects of Larodopa. In pregnancy, weigh potential benefits against possible hazards. Do not use in nursing mothers. Safety of Larodopa in children under age 12 not established.

Precautions: During extended therapy, periodic evaluations of hepatic, hematopoietic, cardiovascular and renal function recommended. In diabetic patients, control may be adversely affected; careful, frequent monitoring and proper adjustment of antidiabetic regimen required. Patients with chronic wide angle glaucoma may be treated cautiously provided intraocular pressure is well controlled and patient is monitored carefully. Monitor carefully patients receiving antihypertensive agents or psychoactive drugs concomitantly, or those with history of convulsions. If general anesthesia is required, dis-

continue Larodopa 24 hours prior to surgery; monitor cardio-respiratory functions carefully. Patients who improve on Larodopa therapy should resume normal activities cautiously. May be used concomitantly with other antiparkinson drugs with possible reduction in dosage of each.

Adverse Reactions: *Most frequently occurring:* nausea, anorexia, emesis, cardiac irregularities, orthostatic hypotension; choreiform, dystonic and other adventitious movements; dizziness, sedation, dyskinesia; psychiatric symptoms such as agitation, anxiety, confusion, depression, hallucinations, delusions, insomnia, nightmares, and mental changes including paranoid ideation and psychotic episodes. *Less frequently occurring* and listed according to system: **psychiatric**—suicidal tendencies, increased libido with serious antisocial behavior, euphoria, lethargy, stimulation, fatigue and malaise, dementia; **neurological**—ataxia, convulsions, faintness, impairment of gait, headache, increased hand tremor, akinetic episodes, torticollis, trismus, oculogyric crisis, weakness, numbness, bruxism; **gastrointestinal**—constipation, diarrhea, epigastric and abdominal distress and pain, flatulence, eructation, hiccups, sialorrhea, difficulty in swallowing, bitter taste, dry mouth, tightness of mouth, lips or tongue, duodenal ulcer, gastrointestinal bleeding, burning sensation of the tongue; **cardiovascular**—nonspecific ECG changes, palpitations, hypertension, flushing, phlebitis; **hematological**—hemolytic anemia (1 case); **dermatological**—sweating, edema, hair loss, pallor, rash, bad odor; **musculoskeletal**—low back pain, muscle spasm and twitching, blepharospasm, musculoskeletal pain; **respiratory**—feeling of pressure in the chest, cough, hoarseness, bizarre breathing pattern, postnasal drip; **urogenital**—urinary frequency, retention, incontinence, hematuria, nocturia, and one report of interstitial nephritis; **special senses**—blurred vision, diplopia, dilated pupils, activation of latent Horner's syndrome; **other**—fever, hot flashes, weight gain or weight loss.

Nausea, anorexia and vomiting usually obviated by temporary dosage reduction and/or administration with food. If cardiac arrhythmias occur, discontinue and institute other antiparkinson therapy. Reduce dosage when involuntary movements occur.

The following have been noted: elevation of BUN, SGOT, SGPT, LDH, bilirubin, alkaline phosphatase or PBI; occasionally, reductions in WBC, hemoglobin and hematocrit; elevations of uric acid with use of colorimetric method but not with uricase; rarely, positive Coombs test; dark sweat and urine.

Dosage and Administration: Because of the strong possibility of adverse reactions and the necessity for individualizing therapy, the physician should thoroughly familiarize himself with the information in the package insert before instituting therapy.

How Supplied: *Tablets*, pink, scored, containing 0.25 Gm levodopa (imprinted Roche 57) or 0.5 Gm levodopa (imprinted Roche 56)—bottles of 100 and 500.

Capsules, containing 0.25 Gm levodopa (pink and beige, imprinted Roche 55) or 0.5 Gm levodopa (pink, imprinted Roche 54)—bottles of 100 and 500.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



Abdominal hysterectomy would appear to be safer than using the vaginal route, in the experience of Mercer Hospital.

Abdominal Versus Vaginal Hysterectomy*

A Morbidity Study

Ralph W. Ellis, M.D./Trenton

Morbidity rate in all hysterectomies at Mercer Hospital during a five year period (1964-1968) was studied by the Infection Committee. A total of 741 cases were reviewed. A patient was considered "morbidity" when the temperature was greater than 100.4 on any two successive days, exclusive of the first post-operative day.

A morbidity rate of 32 per cent was found in all abdominal hysterectomies. A rate of 28 per cent had been found in 1951 by Leventhal and Lazarath.¹ A 10 per cent escalation of the morbidity was noted where there had been any associated removal of either or both adnexa. Subacute inflammatory disease and preoperative anemia also led to an increased morbidity.

Where the vaginal route of uterine removal was employed, there was a 46 per cent morbidity rate. In the reported literature, this has fluctuated between 40 and 53 per cent. An increased rate is associated with additional surgery of adnexal removal or vaginal plastic procedures. In vaginal hysterectomy, urinary retention with infection is a common cause of morbidity. When abdominal hysterectomy is carried out, paralytic ileus, venous thrombosis, pulmonary embolism, and ureteral injury are common.

In our series, two patients suffered from a ureteral ligation resulting in a ureterovaginal fistula and an eventual nephrectomy. One

* This work is from the Mercer Hospital, Trenton (NJ). Case reviews are by courtesy of Mrs. Barbara Palakow of the Department of Medical Records.

Hysterectomies
The Mercer Hospital
(1964-1968)

	1964	1965	1966	1967	1968	Total	Percentage
Total							
Hysterectomies	136	137	145	152	171	741	
Abdominal Hysterectomies	117	123	120	133	151	644	87%
Supracervical Hysterectomies	5	4	9	3	4	25	4%
Abdominal	37	32	42	41	59	211	32%
Morbidity	(31%)	(26%)	(35%)	(30%)	(38%)		
Vaginal Hysterectomies	19	14	25	19	20	97	13%
Vaginal	8	6	9	9	13	45	46%
Morbidity	(42%)	(42%)	(36%)	(47%)	(65%)		
Malignancy	16	18	13	15	17	79	10%
Death	0	0	2	0	1	3	0.4%

patient with rectovaginal fistula was encountered but this spontaneously healed. The bladder was inadvertently entered in three cases. Repair was carried out without deleterious effect. Three deaths occurred in the series. One patient died on the seventh postoperative day with pulmonary embolism and another on the eleventh postoperative day from a staphylococcus infection with abscess formation. A third patient expired on the seventieth postoperative day from an old tuberculosis infection which produced a terminal tuberculous meningitis.

To decrease morbidity associated with these operative procedures it is essential that a meticulous preoperative medical evaluation be made. Any deficiency in the hematologic system should be corrected. Surgery should be deferred if recent acute pelvic inflammatory disease has occurred. In an elective procedure,

in an obese patient preoperative weight loss is mandatory. Increased morbidity and mortality are associated with overweight patients. Local vaginal and cervical infections also raise the morbidity rate. Such infections should be corrected preoperatively. With the use of preoperative penicillin suppositories, observers have reported reduction in the morbidity to as low as 13 to 23 per cent.

Summary

The vaginal route of uterine removal has been found to be associated with a greater morbidity. Adequate preoperative medical evaluation with systemic and local corrective therapy is mandatory, if the morbidity rate is to be lowered.

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1. Leventhal, M. L. and Lazarath, M. L.: *American Journal of Obstetrics and Gynecology*, 61:289 (1951)

333 West State Street

RMP: Education—Not Direct Patient Care

The American Medical Association supports extensions of the Regional Medical Programs and, with some reservations, the program for Comprehensive Health Planning and Public Health Services.

Testifying before a House Public Health and Welfare Subcommittee, Dr. Bland W. Cannon, of the Council on Medical Education, emphasized that the AMA believes that RMP "should continue as a program of continuing medical education, with patient care being limited to demonstrations as an adjunct of the education and research processes."

He explained, however, that the AMA opposes legislation that would combine the individual programs. Such a combination, he feared, would result in a change toward em-

phasis on patient care in RMP.

"We would view with grave concern any attempt to change this essentially educational program to a program for the provision of health services," Dr. Cannon said. "The medical profession today generally views RMP as a means of aiding the physician to provide better care to his patients. It is this attitude which has brought about the outstanding cooperation between practicing physicians and RMP and which has been a major cause of success for the program thus far. If RMP returns to an earlier concept of providing services to the patient, rather than its present goal of assisting the individual physician to treat the patient more effectively . . . the program's beneficial accomplishments will then be diminished."

Increasing success in the treatment of diabetes means that more diabetics will live long enough to get retinopathy.

The Natural Course Of Diabetic Retinopathy*

Joseph C. Patti, M.D./Jersey City

Because of the increased longevity of persons with diabetes mellitus, its more chronic changes have become manifest. The ravages of diabetic retinopathy have far-reaching social, emotional, and economic consequences. This has become one of the prime areas of investigation and teaching in ophthalmology. In 1940, only 4.3 per cent of blindness was caused by diabetes. The prevalence had increased to 18.4 per cent in 1962.¹ It, therefore, becomes incumbent upon the general practitioner, internist, pediatrician, and ophthalmologist to become familiar with the retinal changes in diabetes.

The natural course of diabetic retinopathy is best considered within the framework of a simple classification into non-proliferative and proliferative changes with the corresponding ophthalmoscopic picture and fluorescein angiography.

Non-proliferative Retinopathy

Microaneurysms represent the earliest manifestations of diabetic retinopathy and typically appear first in the posterior pole (particularly in the region temporal to the macula) as small dark red spots. They are sometimes difficult to distinguish from hemorrhages but generally are perfectly round and do not change over a period of months. They frequently have a central reflex and appear in clusters gradually developing throughout the posterior pole.

Microaneurysms are seen generally on the

venous side of the capillary and in the early stages of development will be sharply outlined by fluorescein angiography without late leakage of dye. More advanced microaneurysms will show late leakage of dye indicating increased permeability. Hyalinization may occur which is manifest by a yellowish halo or reflex suggestive of a capsule. The microaneurysm may not be demonstrated by fluorescein because of the presence of packed-in red blood cells. It is possible that the hyalinization could prevent visualization of dye within the microaneurysm. Patency would be confirmed by the presence of late leakage.

It has been proposed by Cogan and Kuwabara² that there is a loss of mural cells at the capillary level, with resultant loss of "vascular tone," resulting in dilatation of some capillaries with increased flow, with subsequent atrophy and obliteration of adjacent vascular channels. These remaining vessels were called "shunt" vessels and connect arteries with veins or veins with veins. The ensuing ischemia, it is postulated, is responsible for the hypercellularity and microaneurysmal dilatation surrounding the shunt.

Other authors feel that the capillary obliteration occurs first with secondary dilatation and hypertrophy of adjacent vascular channels which accommodate a larger flow of blood.³

The microaneurysms and adjacent dilated

* Read before the Section on Ophthalmology, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 18, 1970. Dr. Patti is an instructor at the New Jersey College of Medicine and Dentistry, Department of Surgery, Division of Ophthalmology.

vascular channels are thought to become increasingly permeable, with resultant leakage of fluid, and lipo-proteinaceous material into the outer plexiform layer which are visualized as retinal edema and "hard" exudates respectively. This retinal edema can be demonstrated by the late pooling of dye in the macular area in the late stages of fluorescein angiography. This intraretinal edema is a prominent cause of impaired vision in the pre-proliferative phase. Unfortunately these lesions take months or years to change, the edema usually persisting.

Soft *exudates* ("cotton-wool") are noted early in the course of diabetic retinopathy. They are thought to be due to ischemic infarction of the inner retinal layers, the pathogenesis being similar to that which occurs in essential hypertension. These lesions are paler and less distinct than their hypertensive counterparts.

Hemorrhages occur in widespread distribution and are of varying size being referred to as "dot and blot" hemorrhages.

The caliber of veins may vary even in normal individuals so that it is difficult to assign great value to this. More important is the variation of localized areas of dilatation, the so-called "beading" of veins. These changes are often associated with venous loop formation and surface neovascularization of the retina and are accompanied by slowing of the blood column. The beading may then be a result of partial obstruction of capillaries or arterioles and represents a manifestation of vasoproliferation.⁴

Proliferative Retinopathy

Retinopathy is said to have entered the proliferative phase when neovascularization can be seen ophthalmoscopically. These changes usually begin on the optic disc, but may be observed initially along the main vessels usually temporally. They are usually not seen in the macular area or anterior to the equator.

Neovascularization of the retina is probably due to localized areas of ischemia possibly

related to the hypercellularity in the region of the "shunts." These vessels develop from the venous side of the capillary bed as witnessed by the fluorescein angiograms which will outline them only in the capillary-venous phase. Late in the study the dye will be readily seen to leak out and stain the surrounding area. This reflects the increased permeability of these vessels. It has been suggested that the vessels themselves⁵ or the leakage of fluid itself may damage the vitreous and ultimately lead to vitreous contraction with resultant hemorrhage and late retinal detachment.

Associated with neovascularization may be accompanying fibrovascular tissue proliferation. Occasionally the new vessels may disappear spontaneously giving the erroneous impression of resolution. The fibrous tissue remains as evidence of the proliferative phase.

The unfavorable prognosis of retinal neovascularization is due to the presence of *vitreoretinal adhesions*.⁵ The vessels will proliferate along the vitreoretinal interface and develop firm adhesions. When the vitreous contracts producing a localized simple posterior detachment there will be either a hemorrhage due to the tearing of these fragile vessels or the retina will be pulled off at that point.

Hemorrhage may occur posterior to the detached vitreous framework and usually is resorbed rapidly. Hemorrhage into the formed vitreous is usually very slow and incomplete and accelerates syneresis and vitreous shrinkage.⁶

In the terminal stages advanced retinitis proliferans develops or total retinal detachment ensues. In some cases there is clearing of the vitreous hemorrhage, reduction in the number of retinal hemorrhages, decrease in the dilation and beading of retinal veins and regression of neovascularization which is often erroneously misinterpreted as beneficial effects of therapy.⁵

Treatment

Treatment of diabetic retinopathy should be aimed at minimizing neovascularization, since

it is the presence of these vessels which leads to vitreoretinal adhesions, subsequent vitreous contraction and the aforementioned downhill course. Vision is simply not a good criterion for the institution of therapy with light coagulation. The macula and vision may be uninvolved while the surrounding retina is severely affected. Treatment would be more effective if instituted in the early neovascular stage.

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37 Briarwood Road

Help For A Troubled Child

In *Help For Your Troubled Child*, a new Public Affairs pamphlet, Alicerose Barman and Lisa Cohen discuss the kinds of behavior that call for treatment. The pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York 10016.

The range of normal behavior is wide, the authors point out, and parents should expect to see "individual differences in intellectual ability, motor coordination, temperament, disposition, sociability, ways of learning, and life styles. . . ." But professional help should be sought when the parents' honest responses to the following questions indicate cause for concern:

(1) Is the child's behavior very different from that of his (or her) peers?

(2) Does he lack the ability to direct his impulses, to control himself, as might be expected at his age?

(3) Does he have trouble getting along with children his own age?

(4) Is he having difficulty learning?

(5) Does he have recurring physical symptoms?

(6) Is the child so withdrawn or so aggressive that his behavior worries you?

As a guide for parents who are seeking help, the authors explain the differences between the professional people and agencies qualified to offer counseling—psychiatrists, psychologists, social workers, mental health clinics, family service agencies, school psychological services, and so on. The search for a qualified person might begin with a family physician or pediatrician, your minister, or a local hospital or medical society.

"The minimum requirement for successful treatment," they stress, "is that the parents respect the therapist enough so that they will not consciously or unconsciously undermine the treatment." When treatment itself begins, explain to the child that the therapist is the person to whom he can tell his worries and he will try to help him.

Sometimes, of course, parents may have worried needlessly. They may learn, after the initial interview, that the problems "are well within the range of normal behavior."

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Ketalar[®] — A New, Short Acting Anesthesia

Henry A. Connolly, Jr., M.D./Summit*

This is a report on the new anesthesia Ketalar[®] (ketamine hydrochloride) which, on February 19, 1970, was approved and released by the F.D.A. These observations followed an official study of 100 cases where Ketalar[®] was used as the anesthetic agent. The age range covered by this investigation was from a 5 week old infant to an 88 year old man. Besides acquainting the general medical community with the anesthetic effect of Ketalar[®] it is also the purpose of this paper to indicate some of the important areas in anesthesia practice where it is useful.

From my experience, pediatric anesthesia will benefit the most from this new anesthetic, the main reasons being safety as well as simplicity of administration with rapid onset of analgesia.

Ketalar[®] is a white crystalline solid, melting at 259° C. It is soluble in water to a 20 per cent clear colorless solution. A 10 per cent aqueous solution of ketamine hydrochloride has a 3.5 pH and the base component is 87 per cent of the salt.† Ketamine hydrochloride is 2-(O-chlorophenyl)-2-(methylamino) cyclohexanone hydrochloride.

Ketalar[®] is a cataleptic analgesic with a safe and wide dosage range for general anesthesia. Administered intravenously or intramuscularly, the drug has a rapid onset and a short duration of action. There is practically no suppression of respiration and in some instances respirations have been stimulated. The airway remains patent since the pharyngeal reflex is enhanced. Blood pressure is

slightly elevated by the apparent effect of Ketalar[®] on the central cardiovascular regulatory mechanisms. This anesthesia should be avoided in any patient with hypertension or cerebral vascular disease.

The drug is quickly metabolized in the body. Very little unchanged Ketalar[®] is excreted in the urine. Normal liver and kidney function is maintained whether this drug is administered singly or repeatedly over a long period of time. Intravenous administration of Ketalar[®] with the dosage of one milligram per pound produces surgical anesthesia within 30 seconds. The anesthetic effect lasts about ten minutes. Additional small amounts of the drug may be administered intravenously to maintain anesthesia as required. The intramuscular route has a dosage range of five milligrams per pound and can be used where there is difficulty in finding a suitable vein. When Ketalar[®] is given intramuscularly, surgical anesthesia sets in about three minutes following the injection, and lasts about twenty minutes. Atropine, scopolamine or other drying agent should be pre-operatively given, and at the normal interval (30 to 45 minutes) prior to induction.

In this study, infants and small children were held tenderly and protectively in the arms of the nurse during the Ketalar[®] induction phase. These children all received Ketalar[®] by intramuscular injection. Drowsiness began

*Dr. Connolly is the Chief of Anesthesia, Overlook Hospital, Summit, New Jersey. This study was supported in part by a grant from Parke Davis Co. official investigation #CI 581-143.

†Corssen, G. and Domino, E. F.: *Anesthesia and Analgesia*, 45:29 (January-February 1966)

in a minute or two. The phase of surgical anesthesia was reached in about three minutes. None of the children investigated here had any complications either during anesthesia or during recovery. Awakening was calm and gentle.

Ketalar® is best used for short procedures. However, no problems have been experienced following its use in procedures lasting several hours, or in repeated anesthetics. As an induction agent it is compatible with any of the commonly used general anesthetics. Narcotics and barbiturates are potentiated by Ketalar® and may prolong the recovery time.

For this study it was used as a general anesthetic in the following procedures: skin grafts, dental extractions, sigmoidoscopy, rectal surgery, change of painful dressings, breast biopsy, pyloric stenosis, closed reduction of fractures, circumcisions, appendectomy, hysterectomy, hernia repair, eye surgery and many others. There is poor muscular relaxa-

tion with Ketalar® alone. It should be supplemented with other anesthetics for deep abdominal surgery.

During recovery from anesthesia, an occasional adult patient may go through a phase of dreaming accompanied by confusion and irrational behavior. This is easily controlled by avoidance of tactile or verbal stimulation or, if necessary, sedation with a short acting barbiturate.

Conclusion

Ketalar® is a short acting anesthesia with a rapid onset of action and may be given intramuscularly or intravenously. It is compatible with all commonly used general anesthetics, so that it can be used as an induction agent. The only undesirable characteristics of this drug (which may occur in adults) is elevated blood pressure and pulse rate and emergence reactions. Because of its simplicity and safety, Ketalar® appears to be an excellent pediatric anesthesia.

159 Mountain Avenue

Medicare And Pre-Admission Testing

Proposed amendments to Medicare regulations would tend to shorten hospital stays by providing payment for preadmission diagnostic testing procedures. This will, in effect, extend the amount of time during which outpatient diagnostic services would be considered *inpatient* hospital services and thus reimbursable under the hospital insurance part of Medicare. The days on which the tests are made would *not* be counted against the number of days of hospitalization for which the beneficiary is eligible for payment. The beneficiary would also be relieved of the 20 per cent coinsurance expense which he must now pay for outpatient diagnostic tests. And the hospital would not be required—as it is now—to prepare separate billing forms for inpatient hospital services and diagnostic tests

of this type. Under present regulations, such services are reimbursable only if the beneficiary is admitted to the same hospital before midnight of the day following the day he received the services.

Under the proposed regulations, the testing would be considered inpatient hospital services if the beneficiary is admitted to the same hospital within seven days after the day the last test was given.

Among other requirements the tests must be given by order of the beneficiary's physician and must be necessary after admission if they had not been given on an outpatient basis. They must, in addition, be medically valid at the time of hospital admission.



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Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision. Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and the use of oral contraceptives. There have been three principal studies in Britain^{1,3} leading to this conclusion, and one⁴ in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated

after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test and pregnanediol determination.

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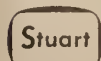
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The Sociologic Aspects Of Marriage*

James L. Mathis, M.D./Richmond, Va.

The pairing of males and females in a more or less permanent arrangement is an ancient social habit not restricted to homo sapiens. This habit had already become a social custom by the dawn of man's recorded history. However, marriage as a social institution regulated by codification probably is a relatively recent product of Menes (Narmer), the first great leader of ancient Egypt.¹

Marriage is a social institution rooted in the family, rather than the family in marriage. After all, it is primarily for the benefit of the young of the family that man and woman continue to live together. It is questionable whether the benefits to the male would have been sufficient to perpetuate the institution. Species survival depends upon the perpetuation of life through offspring. Survival of a culture depends upon the family unit to transmit its patterns to the young. Thus marriage is dependent upon the family for its existence, and the family will change as does the culture it exists to transmit.

This discussion will be confined to middle class United States, primarily urban or suburban. A discussion of sub-cultural variations is a task beyond the scope of this paper.

Marriage occurs in every known society, but its forms vary according to the needs of that society.¹ A social institution does not continue to exist for centuries unless it serves a function. Some of its major functions in our society are:

1. The transmission of culture from one generation to another.

2. The physical and emotional care of children.
3. The protection and maintenance of the female.
4. The legalization of sexual rights.

An alteration of values means an alteration of the institution. So, the sociology of marriage, like all aspects of our lives, is changing with increasing rapidity. Historical facts may be evident, but present data are less certain and future projections require almost pure guesswork. The factors that appear operative at this time are:

1. The loss of the extended family.
2. The tendency toward unisex: (a) redefinition of masculinity and femininity; (b) sexual and economic equality of the female; and (c) declining value of the role of housewife.
3. The devaluation of child raising.
4. The abdication of parental rights and responsibilities.
5. The effects of affluence.
6. The changing attitude toward divorce.
7. The mobility of family units.

The interrelationship and overlap of these factors will become even more evident as we discuss them.

1. The loss of the extended family: The nuclear family of father, mother, and children now exists in place of the extended family of the past. Economic advancement and indus-

* Read before the Section on Psychiatry and Neurology, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1970. At that time Dr. Mathis was associate professor of Psychiatry at Rutgers Medical School, New Brunswick, New Jersey; he is now professor and chairman of the Department of Psychiatry at the Medical College of Virginia, Richmond, Virginia.

trialization have destroyed the extended family living in a circumscribed area and consisting of parents, siblings, grandparents, aunts, uncles, cousins, and so forth. Much of the guiding and supporting influence of the relatives is no longer present. This forces the nuclear family members into complete dependence upon and in continual contact with each other. Emotional crises are intensified and confined to this small unit, and those which cannot be resolved in this context must be parceled out to impersonal and frequently overloaded social agencies. Family members have no middle ground for working out the vicissitudes of living together; they must either go it alone or turn it over to outside arbitrators who, however well intentioned, are limited in influence.

2. *The tendency toward unisex:* The distinct polarization of the sexes is now history. Several factors may be operative in the tendency toward unisex. Three are:

a. *The redefinition of masculinity and femininity*—The day of the subsistence society is gone. The great need for brawn and endurance is historic and even that is being devalued. Whatever horizons are to be conquered now demand brains and intellectual activity; not muscle. The masculine role no longer contrasts with the feminine, but rather complements it or runs neutrally by its side. Masculinity is a concept which a society defines according to its needs, and it is not, therefore, stable.²

b. *Sexual and economic equality of the female*—Modern woman has been told what many already knew; that sex can be fun for her too. The age of the female orgasm without moral overtones coincided with the new era of freedom from fear of pregnancy. A sexual evolution which began in World War I has reached a point where sex can be talked about openly, and in the process, sexual intercourse may have become less a thing of passion than an act of play. The male always has allowed himself sex purely for momentary entertainment, but he until recently has denied this right to the female for many complicated reasons.

Sexual equality goes hand in hand with economic equality. Only when the female can afford independence can she make any demands in her own right, sexual or otherwise. Modern standards frequently require two incomes because of the snowballing effect of increasingly available material goods. Today over three-fifths of married women contribute to the family income and one-third of all workers are female.³

c. *Declining value of the role of housewife*—Simultaneously, the social value of being a housewife has declined. It is referred to as "only a housewife" or "just a housewife" in order to devalue the designation. In effect, this mirrors the devaluation of the family. The woman who lacks complete security in her own right may find self-esteem difficult to maintain unless she can identify herself with some outside agency, job, or profession. Her energies will no longer be focused on the husband, children, and the home, but will be divided with the "other life."

3. *Devaluation of child rearing:* Evolution may have little concern for a single species, or it may simply have played a monstrous joke on man. At any rate, the very drive toward reproduction which insures species survival may well have determined man's destruction. Over-population with its sequelae is the greatest threat facing mankind today. The growing awareness of this has reversed the previous social attitude toward the family. Large numbers of children are no longer viewed with pride, but are realistically seen as a social evil. Even within the family, children are no longer the tangible assets they once were in rural settings. Inflation and urban living have made them a costly commodity with decreasing positive returns.

4. *The abdication of parental rights and responsibilities:* The loss of the extended family has forced the nuclear family to turn to the outside for help with its internal problems. The post-war concepts of equality, freedom, and permissiveness became confused with rights, duties, and responsibilities. Authority became a word ranking between bad and

obscene. Concern with immediate feelings became over-emphasized, and child rearing took on the complexities of nuclear physics. Parents became afraid of their children, unsure of their own ideas and attitudes, and began to abdicate the family responsibility and turn it over to third parties—usually impersonal agencies. The idea of two people working together to raise the family according to their own standards and values became passé. The family role of culture bearer began receding into history.

5. *The effects of affluence:* Hermann's formula is "the number of marriages in any period expresses the expectations of the economic prosperity prevailing at that time." Modern marriages reflect this in the decreasing age of marriage among the middle classes. Simultaneously, more people are seeking advanced degrees as the value of the simple college education declines, thereby prolonging the dependency period. Approximately 50 per cent of these late adolescent marriages fail before the fifth year.⁴ Early marriage also increases the possibility of producing larger numbers of children, an undesirable side effect.⁵

Affluence also has made possible the spread of family energies and commitments. Leisure time no longer is spent in the home, and when it is, objects and things have replaced interpersonal relations.

6. *The changing attitudes toward divorce:* A short while ago divorce was a disgrace for all except the two extremes of the socio-economic classes. Marriage was a distinct part of the moral value system and was considered part of the religious aspect of the family and community. It rapidly has become more purely a legal contract for the protection of property rights and individual freedoms. The religious rituals remain as matters of form, but the content is virtually without meaning.

7. *The increasing family mobility:* Mobility undreamed of a few decades ago now occurs

on two planes. Geographic mobility is a necessity in rapidly growing industrial societies, and upward socio-economic mobility is the great American dream for which all else can be reasonably sacrificed. Today it is even more than a dream, it is a right. The nuclear family does not take root deeply in a community in which its ties are purely economic. The upward social mobility is not directed toward an end, but rather has become a goal in itself.

The consequences of all these changes cannot be predicted because they are dynamic and still in process. Marriage as a social institution must continue to change, because the family is in this dynamic relationship with a culture which is changing at almost revolutionary pace. The family as a transmitter of culture may be on its way to extinction. Schools and governmental agencies are taking greater and greater responsibility for this function. If this is true (and it is considered with the fact that smaller and smaller family units must occur), then these two factors may indicate increasingly less need for a stable institution of marriage. Children may be cared for physically and emotionally by third party professionals, although this seems less than optimal. Sexual freedoms may soon be accepted in a manner that no longer requires legalization via ceremony. Equal rights of the female in the economic world now make her capable of caring for herself. There are then, some indications that the functions served by the institution of marriage as we know it are no longer valued by our society. An institution not serving a function must be discarded or altered radically.

The medical profession and its ancillary branches will become more and more involved because a system in the process of change is more vulnerable to stress. Rapid and radical change always catches many people with one foot in each of two eras. These stresses will produce problems which will be presented to outside agencies for solution, and one of these agencies is the physician. Another reason for medical involvement is that marital difficulties

frequently present as sexual problems or somatic difficulties with sexual overtones. All generalities are suspect, including all of these, but a good rule of thumb is that sexual problems in marriage (excluding the overt pathologies) are symptoms of marital difficulties rather than entities in themselves. Competent diagnosis and proper guidance requires an understanding of what is going on in current social institutions.

Purely personal factors also enter the picture in that physicians are middle class members of society, usually married, and usually with children. They, therefore, have a dual interest

in the process which influences both their professional and private lives.

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Medical College of Virginia

Dying Of Rescue Efforts

The Employers Insurance Company of Wausau, in a recent bulletin, comments that, "Dying on the way to a hospital is the ultimate insult, isn't it? When you survive an accident, you'd also like to be allowed to survive the aid of your rescuers. But last year 20,000 people made it only over the first hurdle. The second was too much for them. They became victims of double jeopardy.

"They died (and another 25,000 were permanently disabled) because they were lifted when they should have been left alone, or because they weren't treated for shock or didn't get enough oxygen or ran out of blood on the way to the hospital.

"In many states a hairdresser is required to have more training than an ambulance attendant. Only 18 of our 50 states regulate ambulance personnel training at all.

"Death and maiming by double jeopardy is a community problem. Its remedy begins with an awareness by community leaders of the need for trained personnel, improved equipment and communications."

The "remedy" is now being advanced by a vigorous program conducted jointly by the AMA and the Junior Chamber of Commerce. Dr. Irvin E. Hendryson, Vice-Chairman of the AMA Board of Trustees, and Chairman of the AMA Commission on Emergency Medical Service, explained that, "We believe that the Jaycees, with a manpower resource of 325,000 young men across this country can become the effective community catalysts in bringing to the attention of the public the need for standardized emergency vehicle equipment, properly trained medical attendants, and a better communications system between emergency vehicles and hospitals.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

November 15, 1970

A regular meeting of the Board of Trustees was held on November 15, 1970, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Symposium—"The Physician's Assistant" . . .
Agreed to join the Academy of Medicine in sponsoring a symposium on "The Physician's Assistant"—to explore and make suggestions to relieve the manpower shortage in the health field in New Jersey.

Liability of Hospitals and Blood Banks Furnishing Blood or Other Human Tissue . . .
Received the following report of Legal Counsel concerning the accountability of hospitals and blood banks furnishing blood and other human tissue: (This report had been prepared in compliance with a request from the Board of Trustees, after it was learned that a recent decision of the Illinois Supreme Court had declared that both hospitals and blood banks are "strictly liable" to patients who contract transfusion-induced hepatitis, even without proof of negligence.)

Accountability of Hospitals and Blood Banks Furnishing Blood or Other Human Tissue

1. Case law in New Jersey is unclear on the issue of whether a commercial blood bank or hospital may be held accountable on the basis of implied warranty or strict liability in tort where the furnishing of blood or other human tissue results in consequential injury.

2. This issue has been considered in the recent cases of *Jackson vs. Muhlenberg Hospital* (96 N.J. Super 314—Law Div. 1967—53 N.J. 138—1969—Supreme Court) and *Baptista vs. Saint Barnabas Medical Center* (109 N.J. 217 Super Crt, Appellate Div.). In each case the court elected to rely upon the principles of negligence rather than upon the doctrine of implied warranty or strict liability in tort. The dissenting opinion in the *Baptista* case stresses the steady progress of the law toward implied warranty and strict liability in tort. I suspect the pendulum will swing to the dissenting opinion views unless stayed by statute to the contrary.

3. In the case of *Jackson vs. Muhlenberg Hospital*, the plaintiff contended she had contracted hepatitis attributable to blood transfusions and based her complaint against the hospital and blood bank on negligence, express and implied warranty. The trial court held the presence of hepatitis virus in the blood furnished did not give rise to any cause of action sounding in implied warranty or strict liability in tort. The Law Division of the Superior Court held that the transaction was a "sale" and that the supplying blood bank and hospital should be held liable for the harm caused by the defective product or blood they "sold." On appeal to the Supreme Court, the plaintiff abandoned that part of her complaint based on negligence and relied solely upon the doctrine of implied warranty and strict liability in tort. The Supreme Court evaded this issue by reinstating the negligence count in the complaint and remanding the case to the trial court for further hearings.

4. In the case of *Baptista vs. Saint Barnabas Medical Center*, the Superior Court, Appellate Division, referred favorably to the *Jackson* case and on the complaint of injury caused by transfusion of incompatible blood held in the absence of proof of negligence there was no liability for death of a patient on the grounds of implied warranty or strict liability in tort. The dissenting opinion of this case stresses the steady progress of the law toward implied warranty and strict liability in tort.

5. Legislation introduced by Senators Wallwork, Maturi, Guillian, DelTufo and Dowd in 1968, known as S-334, would have resolved the problem by amending the Uniform Commercial Code to provide that implied warranties of merchantability and fitness (liability without fault) shall not be applicable to a contract for the sale of human blood, blood plasma, or other tissue or organs but shall be considered as medical services. This bill advanced to second reading in the Assembly but did not pass. This year the same bill, known as S-752, has been introduced by the same sponsors. Since its introduction this bill has not been released from committee. The Medical Society of New Jersey is giving this bill active support and urges all concerned with this problem to take appropriate action to enhance its passage.

Arbitration of Medical Malpractice Claims

. . . Authorized Legal Counsel to investigate with American Arbitration Association officials the feasibility of arbitration agreements in malpractice claims in New Jersey.

Council on Legislation . . . Took the following actions on the report of October 22 meeting of the Council on Legislation:

1. Voted to sustain the previous action of disapproval of S-838 (to provide that any M.D. employee of a licensed hospital may perform emergency medical service under the super-

vision of a licensed physician) and of A-929 (to permit noncitizens to be registered as physical therapists)—Council had referred both back to the Board for reconsideration.

2. Approved, as amended, Council's recommended position on bills of medical import:

S-896 —To appropriate \$100,000 to the Department of Health for administration of renal disease program. *APPROVED*

S-913 —To provide that any person 18 years of age or over can donate blood in any voluntary and non-compensatory program without obtaining parental permission. *APPROVED*

S-949 —To provide that a standard serological test for syphilis shall be a test approved by the Department of Health and shall be made at approved laboratories; to permit such laboratory tests to be made free of charge by the Department of Health. *DISAPPROVED*, on the grounds that the bill would impose an economic hardship on the people of New Jersey. The test is mandated by state law and therefore the cost thereof should be borne by the State of New Jersey.

Note: The Board directed that this bill be referred back to Council with the recommendation that the position be changed to approved.

S-951 —To provide for the licensing of medical care facilities and to transfer certain powers and duties from the Department of Institutions and Agencies to the Department of Health. *DISAPPROVED*, because of our position of Approval of A-1203, but also because of Section 16 which would empower Hospital Service Corporations to enter into contracts for the rendering of Medical-Care Services which should be restricted to Medical Service Corporations.

S-956 —To abolish the State Board of Control of Institutions and Agencies and transfer its functions, powers and duties to the Department of Institutions and Agencies and to create therein a State Advisory Council. *DISAPPROVED*, because there is no evidence that a change in the organizational structure would result in the improvement of the operational functions of the present system.

S-960 —To appropriate \$75,000 to the Department of Health for purchase of therapeutic and educational materials for distribution for the treatment of venereal disease. *APPROVED*.

S-977 —To provide a supplementary appropriation of \$1,629,871 for the New Jersey College of Medicine and Dentistry for the fiscal year ending June 31, 1971. *APPROVED*

A-1135—To provide for penalties concerning selling, dispensing or giving away of marijuana and other narcotic drugs. *NO ACTION* in view of enactment of S-851.

A-1163—To empower the board of trustees of the New Jersey College of Medicine and Dentistry to

acquire the Newark City Hospital. *APPROVED*

A-1184—To appropriate \$100,000 to the Department of Education for teacher training projects, community drug education programs and for mobile classrooms for drug education programs. *APPROVED LAW, CHAPTER 228.*

A-1186—To abolish the requirement that the driver of a motor vehicle must give an audible warning by horn before passing another vehicle proceeding in the same direction. *APPROVED*

A-1198—To regulate the sale of non-prescription drugs containing ethyl alcohol, dextromethorphan, phenobarbital, etc. *APPROVED*

A-1203—This bill would transfer all powers, duties and responsibilities of the State Board of Control, the Hospital Licensing Board, the Commissioner of Institutions and Agencies, and the Department of Institutions and Agencies related to medical care facilities to the State Department of Health. (Substitute for A-941) *APPROVED*

Note: The Board deferred action and directed that the bill be returned to Council for reconsideration in view of an article in the November 15 issue of the *Newark Star Ledger*.

A-1207—To require approval, inspection and regulation of narcotic treatment centers by the Commissioner of Health. *APPROVED*

A-1211—To establish a state-wide system of Drug Abuse Treatment and Counseling Clinics under the direction of the Commissioner of Health. *APPROVED*

A-1213—Requires the written consent of a parent or guardian of a pupil, and of a physician of the parent's or guardian's choice, prior to the administration to a pupil by public school authorities of any drug or medication for experimental purposes or for stimulating the learning process. *APPROVED*

A-1216—To direct the Commissioner of Health to combat lead poisoning in children and to appropriate \$100,000. *NO ACTION* in view of position taken on A-1295.

A-1219—To appropriate \$240,000 to the Department of Education for additional expenses incurred in the operation of drug education programs in secondary schools, for implementation of teacher training programs and acquisition of audio-visual equipment. *APPROVED LAW, CHAPTER 229.*

A-1236—To authorize the Commissioner of Health to provide for the care and treatment of drug addicts by public and private facilities, including out-patient care and rehabilitation treatment and to appropriate \$300,000. *APPROVED*

A-1252—To add the Commissioner of Health to the Board of Trustees of the College of Medicine and Dentistry of New Jersey. *APPROVED*

A-1258—To provide that no person shall be fitted with footwear while barefoot and to provide that anyone who violates this act shall be a disorderly person. *NO ACTION*

A-1260—To provide that no person shall distribute, sell or deliver any eye glasses or sun glasses unless they are fitted with heat-treated glass lenses, plastic lenses or laminated lenses and capable of withstanding an impact test of a $\frac{5}{8}$ " steel ball dropped fifty inches and to provide that no person may fabricate, sell or have in his possession frames manufactured from cellulose nitrate or other highly flammable materials. *DISAPPROVED*, because Section 3 of the bill is much too broad and might result in an undue economic burden.

A-1271—To provide that the consent of a minor who is suffering from mental illness to provisions of medical or mental health care or services shall be valid and binding. *DISAPPROVED*, because the bill, as written, is inherently unsound in that it calls for reliable judgment from an individual who by definition is incapable of rendering the same.

A-1291—To provide for the regulation of mass gatherings and for the establishment in the State Department of Health of a Mass Gathering Review Board. *APPROVED*

A-1295—To provide that no person shall apply lead paint to toys, furniture or the interior surfaces of any dwelling, dwelling unit, rooming house, rooming unit or facility occupied or used by children; to authorize the Commissioner of Health to promulgate rules and regulations and to institute legal action if he finds that any municipality is not enforcing provisions of this act. *APPROVED*

A-1307—To provide for a New Jersey Controlled Dangerous Substances Act. *NO ACTION*, in view of the enactment of S-851.

Council on Medical Services . . . Approved the report of the October 21st meeting of the Council on Medical Services, including the following recommendations:

1. That The Medical Society of New Jersey, through its Board of Trustees, record itself as supporting the AMA's objections to repeal of States' Antisubstitution Laws, and encourage the AMA to resist vigorously any future attempts at repeal. Also, that the Board of Trustees convey its opinion to the New Jersey Pharmaceutical Association.

2. That MSNJ record itself as opposing the Bennett Amendment, in support of the AMA's stand. (See page 817, December 1970 issue, *The Journal*, MSNJ)

Council on Mental Health . . . Approved the report of the October 28th meeting of the Council on Mental Health, including the following recommendation:

That each component medical society be urged to stimulate the development of facilities for the detection and treatment of alcoholism and related conditions in cooperation with all medical and social organizations that can assist in such a program. That the county societies and the detection and treatment

facilities be urged to effect close liaison between practicing physicians and the facilities, and that The Medical Society of New Jersey recommend that each of the presently existing alcoholism facilities as well as those established in the future be placed under the supervision of a physician fully licensed by the State of New Jersey.

Council on Public Relations . . . Approved the Council's recommended continuing projects for 1970-1971:

1. Publication and distribution of *Junior Health Hints*; the *Membership Newsletter*; and a *Periodical Newsletter* to cooperating agencies or individuals, as required.

2. Publication of special news releases as required in furtherance of the Society's activities, including (a) Eye Health Screening Program; (b) Annual Meeting; (c) Child Safety Week; (d) Selected Official Programs.

3. Golden Merit Awards.

4. Information Center and Press Releases at Annual Meeting.

5. Orientation program for new members under sponsorship of component societies.

6. Encouragement of statewide emergency medical care coverage.

7. Encouragement of Future Physicians' Clubs.

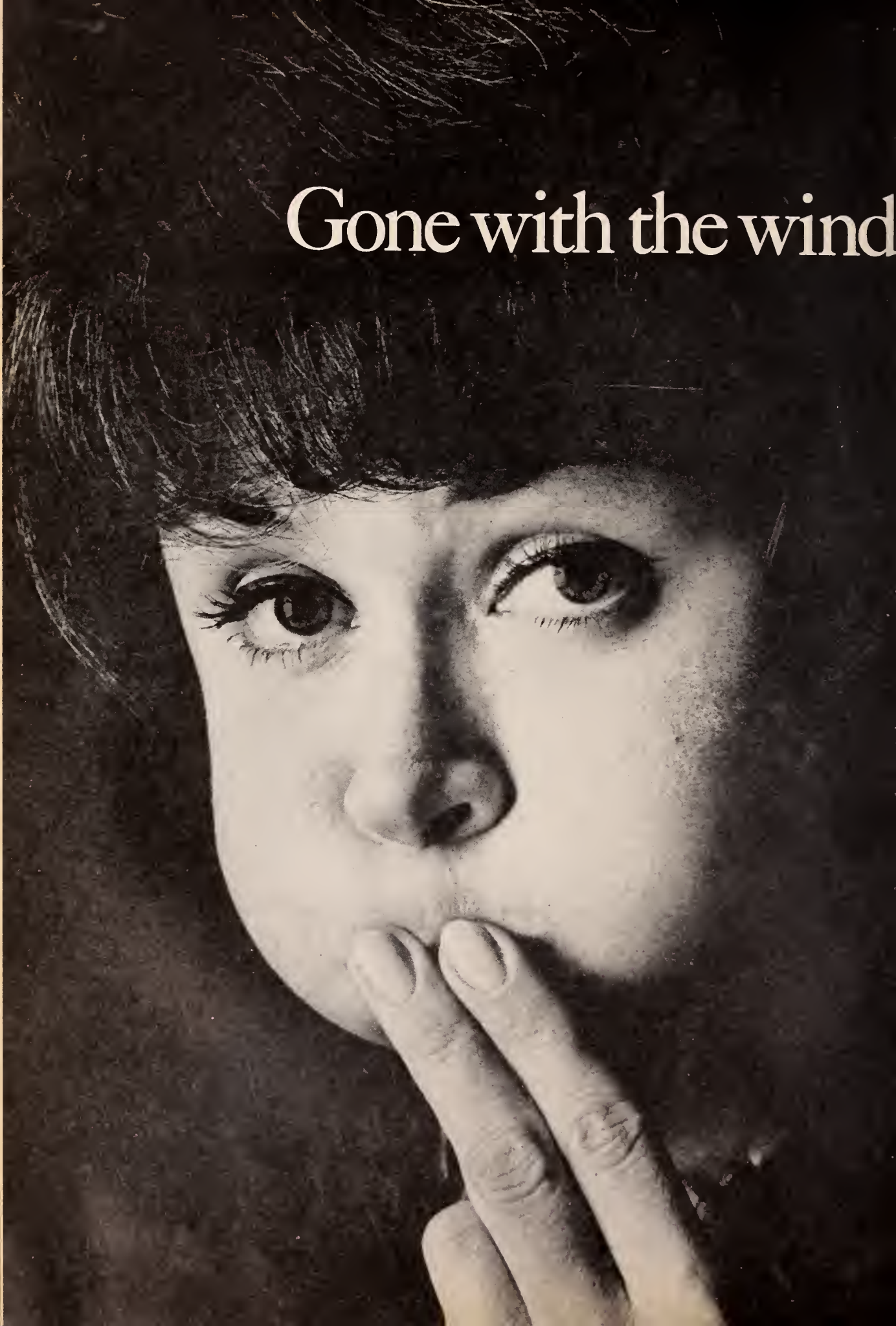
. . . Approved the following recommendation as amended:

That the Board of Trustees address a communication to the Chairman of the AMA Council on Legislation requesting that copies of "Legislative Roundup," a weekly report on national medical legislation compiled and issued by the AMA Council on Legislation, be supplied each week by the AMA Council on Legislation to the chief of staff of each of the hospitals of New Jersey for posting on bulletin boards. (Italics indicate amendment by the Board of Trustees.)

Proctosigmoidoscopic Examinations under Medicare/Medicaid . . . Directed that the following reply, to a communication from the Board of Trustees, from the Medical Director of the governmental health programs under Prudential Insurance Company of America be referred to the Council on Public Health:

"As the Medicare and Medicaid carrier for the State of New Jersey, the Prudential Insurance Company is in complete agreement with the Council on Public Health and the Board of Trustees of MSNJ 'that proctosigmoidoscopic examination related to the complaint is an indicated procedure for patients.' We might also agree with those who would feel that it is an indicated periodic examination even in the absence of symptoms, however, there could not be any reimbursement for such a screening examination under the Medicare Program."

Gone with the wind



The gas/acid group of disorders

'The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together.'*

Frees captured gas...neutralizes free acid

SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

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The pleasant, distinctive flavor of SILAIN-GEL, as well as its non-constipating feature, make it a therapy your patients can live with—in comfort and without complaint.

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when the patient prefers the convenience of a tablet, select

Silain-Gel® Tablets:

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Also available for the patient who needs an antifrothant/antiflatulent agent only: **Silain®** (simethicone) Tablets

*Slanger, A.: Med. Times 94:150 (Feb.) 1966.

Announcing the "Antgasid"

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Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide

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one dose does both: frees captured gas...neutralizes free acid

The actions of the official
Tincture and Extract of
Belladonna result chiefly from
their Atropine content . . .
conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



ANTROCOL[®]

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.



Each tablet or capsule contains:
Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

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Tablet in bottles of
100, 500 and 5000
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of 100, 500 and 1000

Caution: Federal law prohibits
dispensing without prescription.

PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

Clinical supply available to physicians.

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Tepanil[®] Ten-tab (continuous release form) (diethylpropion hydrochloride)

works on the appetite
not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in mid-evening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient—
including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep resfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL, INC.
PHILADELPHIA, PENNSYLVANIA 19144

QuinammTM

(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during November 1970:

	1970 November	1969 November
Aseptic meningitis	30	6
Primary encephalitis	3	6
Infectious hepatitis	216	174
Serum hepatitis	63	36
Malaria—Military	2	10
Malaria—Civilian	0	1
Meningococcal meningitis	8	7
Mumps	219	177
German measles	28	26
Measles	11	9
Salmonella	90	38
Shigella	41	66

Pertussis

Although not a reportable disease, the New Jersey State Department of Health has been informed of six cases of pertussis-like illness from a metropolitan area within the past two months. Diagnoses were made on the basis of clinical evidence, without bacteriologic confirmation. Information indicates that the immunization status of these children was incomplete. The importance of firmly establishing a diagnosis of pertussis must be strongly emphasized, since it is a *preventable* disease.

A definitive diagnosis of whooping cough can be made only by bacteriologic identification of *Bordetella pertussis*. This organism requires a complex medium for isolation, the most suitable being Bordet-Gengou medium which contains blood, potato extract, and glycerol. Penicillin is added to inhibit the growth of other organisms. Inoculation with a nasopharyngeal swab is preferable to the traditional cough plate. Since laboratories do not ordinarily inoculate Bordet-Gengou plates, they must be informed that pertussis is suspected so that the medium may be prepared. The organism is most consistently isolated during the early catarrhal phase of the illness, prior to the onset of the characteristic cough from which the disease derives its name. Culturing siblings of the index case may enhance the chances of recovering the organism.

Pertussis in any community reflects an inadequately immunized segment of the population. The implications of this immunity gap extend beyond pertussis. These children are susceptible to tetanus and diphtheria as well. The documentation of pertussis, then, indicates the need for a vigorous immunization program, particularly among the preschool population.

Foodborne Gastroenteritis, Monmouth County

An outbreak of gastroenteritis occurred in a Monmouth County regional high school in early November. Among 540 students and faculty members who completed questionnaires, 117 persons were ill, an attack rate of 21.6 per cent. The most frequently reported symptoms were abdominal cramps (68.4 per cent) and diarrhea (71.8 per cent) lasting 10 to 14 hours. Notably infrequent in their occurrence were vomiting (6 per cent) and fever (8 per cent). Mean and median incubation periods were 11 to 12 hours. The suspected source of illness was a turkey lunch served in the school cafeteria to about 300 people. An estimated 200 people were ill, probably due to *Clostridium perfringens* which was isolated from both leftover turkey samples and stool specimens by the State Bacteriology Laboratory. No obvious fault was found in reviewing the preparation of the food items; however, prolonged heating at an inadequate temperature may have been the factor responsible for the episode.

Widows and Orphans Society

Support the Society for Relief of Widows and Orphans of Medical Men of New Jersey. Write to P.O. Box 95, Belleville, New Jersey, for information.

AMA's Peer Review Plan

"Peer Review" is the "in" phrase these days. Just as you would not want to review the professional competence of the work of a dentist, so you should not agree to have the quality of your work reviewed by a non-medical monitor. The concept of a Peer Review Organization (PRO) was approved by the American Medical Association's House of Delegates at the 1970 Annual Meeting.

PRO was made a part of the Medigap proposal to finance national health insurance through federal income tax credits. Under PRO, the secretary of the U. S. Department of Health, Education, and Welfare would contract with a state medical society (or any organization designated by a state medical society) for the establishment and operation of a peer review organization in the state.

The agreement could provide for a peer review mechanism established in accordance with certain requirements set out in the bill approved by Congress or under a plan intended to accomplish the same result approved by the secretary and the state medical society.

If the parties agree to the first course of action, PRO would require the state medical society (or the entity it designates) to appoint an advisory council. The commission would appoint local review panels to review the need for and quality of medical services furnished under federally supported programs and the appropriateness of charges for such services. The commission also would appoint local advisory councils.

Each panel would hold hearings and decide if disciplinary action is warranted. If so, it would make a recommendation to the commission. If the commission agrees, it would so recommend to the secretary of HEW who could accept or reduce, but not increase, the recommended disciplinary action.

PRO also provides that the actions of witnesses and commission and panel members

would not be the basis for civil action for libel or slander; that records and evidence developed in the hearing could not be used in other actions, civil or criminal; and that either party could terminate the agreement upon giving notice.

Methadone And The Private Practitioner

The following is relayed to you at the request of the State Commissioner of Health.

A serious increase in trafficking in methadone has prompted the State Department of Health to submit the following comments and recommendations for your consideration. They will be of assistance to practitioners and aid in averting diversion of the drug into illicit channels.

It is urged, with no intention of restricting the practice of medicine, that practitioners avoid over-prescribing. Methadone is a narcotic. As such, its prescription for analgesia or as an antitussive agent should be strictly limited in keeping with good medical practice. When possible, non-narcotic drugs should be prescribed.

Methadone is often over-prescribed in the detoxification of opiate addicts. While dosage must be patient-related, the dangers of methadone overdose cannot be too strongly stressed. The following detoxification schedule, which has proved effective in detoxifying over 90 per cent of all opiate addicts treated, is strongly recommended.

Urine monitoring is required to indicate possible concomitant use of other drugs which can lead to dangerous cumulation. Consequently, the practitioner should have available clinical laboratory services to provide urine monitoring. Medication should be limited to oral dosage forms, and should be administered in the presence of the practitioner, as follows:

- First Day:* 25 milligrams of methadone in divided doses, the first consisting of 15 milligrams. The second dose of 10 milligrams is given 8 to 12 hours later.
- Second Day:* The same dosage as on the first day.
- Third Day:* Two doses of 10 milligrams, the first in the morning, the second 8 to 12 hours later. Urine monitoring should be conducted on this and following days.
- Fourth Day:* A single dose of 10 milligrams.
- Fifth Day:* A single dose of 5 milligrams.
- Subsequent Days:* If additional daily doses are required, 5 milligrams may be given in the practitioner's presence. The detoxification period should not exceed 10 days of therapy nor a total dosage of 110 milligrams in that period.

Methadone is legally classed as an experimental drug when it is used in the *maintenance* of narcotic addicts. It may be used legally *only* by investigators who have an Investigational New Drug Application granted by the Federal Food and Drug Administration. Its use in this area is subject to federal regulations and guidelines or rules which may be established by the State of New Jersey. Only hard core addicts (who have been addicted for at least one year) should be considered eligible for maintenance.

To avoid iatrogenic addiction, before selecting a patient for treatment, you must determine unequivocally that he is indeed a helpless addict. For the youngster who merely experiments with drugs or may be only acutely intoxicated, other forms of treatment are required.

All addicts do not respond adequately to methadone maintenance. The rate of failure is lowest among addicts who believe that methadone represents a real solution to their problems.

The Mobile Coronary Care Unit

Each year thousands of New Jersey heart attack victims die before they can reach a hospital to receive special care. However, at least 85 per cent could be saved if they had access to a mobile coronary care unit. Mortimer L. Schwartz, M.D. (Professor of Medicine and Director of Clinical Cardiology, New Jersey College of Medicine and Dentistry) has reported that, for our state, the annual death toll from heart attacks is 21,000. Of that number, some 14,000 never reach a hospital alive. Dr. Schwartz estimates that "about 85 per cent or 12,000 of these 14,000 victims could live if we could get them into a mobile coronary care unit," such as the one that his team has been operating from Newark's Martland Hospital.

In the last four months, this demonstration mobile coronary care unit has responded to 325 calls. Of that number, 283 patients were actually screened by a physician; 60 were admitted to Martland's coronary care unit; 43 were admitted to the general medical wards at Martland; 32 were taken to other hospitals; 114 were examined and released; 34 died; and 42 calls were canceled or classified as crank calls. Thus, a third of all of the calls received during that month were "absolutely unnecessary."

The mobile coronary care project was first made possible through an initial grant of \$4,500 from the New Jersey Department of Health. Portable, battery-operated equipment (electrocardiograph, monitor-defibrillator, and suction apparatus) was purchased. Each time an emergency call was received this equipment had to be loaded into whatever ambulance was available. This process accounted for a

205th ANNUAL MEETING

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loss of four minutes for each emergency call. With a second grant from the State Department of Health, an old ambulance was remodeled into a special coronary ambulance eliminating the need for loading and reloading equipment. With this, median time for bringing emergency coronary care to a patient's bedside dropped from ten to six minutes.

According to Dr. Schwartz, some \$150,000 is necessary for additional equipment to put this demonstration project out front in coronary care. A gift of \$500 was recently received from the Woman's Auxiliary of the Essex County Medical Society. This, however, is the only such gift received from a "private" organization. The project has had to operate virtually without a budget and to rely upon governmental grants to continue its operation.

The ambulance now operates on a five-day week, eight-hour day schedule. The unit has responded to an average of $1\frac{1}{4}$ calls per day (325 for the first year). It has brought in 50 per cent of Martland's coronary care patients and it has moved closer toward its goal of bridging the gap between the two out of every three heart attack victims who never reach a hospital alive.

Your AMA Dues

Dr. Burt L. Davis, chairman of the AMA Finance Committee, in an interview, explained the AMA's position on dues as follows. For many years, our two main sources of income have been advertising and dues. There are some other sources—subscriptions, books, pamphlets, royalties, sale of exhibit space, and return from our investments—but advertising and dues are our main support.

Ten years ago the AMA got 50 per cent of its income from advertising; only 23 per cent came from dues. This year, we'll get 39 per cent of our income from dues; only 34 per cent from advertising. Dues are our most stable income source. The tax bill enacted by

the last session of Congress contains a provision which levies a tax on profit from advertising in AMA publications. The government intends to tax otherwise tax-exempt organizations for profit-making activities which aren't directly related to their tax-exempt purposes. While this is a disputable matter, the Internal Revenue Service considers drug advertising in scientific journals taxable income. The government has made it obvious to us—and a lot of other tax-exempt organizations—that we'll have to rely upon dues income as the chief source of revenue in the future.

Both dues and advertising income are eroded by inflation, but each dollar of profit from advertising, when taxed, will actually be worth only 52 cents. Overdependence on advertising revenue would put the AMA in a dangerous financial situation.

Four years ago the Board and our accountants agreed that at some point we'd reach an upper limit on our non-dues income. Based on the past few years' figures, that limit appears to be about \$19.5 million, but it'll be less when taxes are levied on advertising. If we had no outside income at all, dues would have to have been \$188 for 1970—to put it another way, each of our members is receiving \$188 worth of services for \$70.

At the beginning of this year, we had \$15.2 millions in liquid reserves, which isn't sufficient to meet the House's requirement of 90 per cent of our operating costs. That would require about \$28 millions in reserves. Further, our reserves must contain money to cover the eventuality that we have a tax liability for advertising revenue for the last three years. In future years, beginning with the fiscal year that starts December 1, 1970, such taxes would come out of operating funds.

The decline in stock prices has hit us just as it did everyone else—at one point our portfolio declined in value about 15 per cent in two months. In the last fiscal year, the value of our securities investments dropped by about \$1.3 million, and this certainly complicates our financial planning.

ANNOUNCEMENTS

Effects of Ionizing Radiation

The National Academy of Sciences-National Research Council invites submission of current data on somatic, genetic, and environmental effects of low-level ionizing radiation, including effects on human growth and development. This material is requested whether or not it has been published. Work in progress which is yet to be reported is of particular interest. The request is made to assist the National Research Council in its deliberations concerning ionizing radiation effects upon human populations. Please send material to the Division of Medical Sciences, attention of A. W. Hilberg, M.D., National Academy of Sciences, 2101 Constitution Avenue, Washington, D.C. 20418.

Cancer—Prevention and Treatment Course

Available to you in Flemington is a series of programs on the prevention and treatment of malignancies. These sessions are held on Saturday mornings at 10:30 a.m. in the Hunterdon County Medical Center, just north of Flemington on Route 31. The lectures and demonstrations terminate at 12:30 with a luncheon. On January 23, the subjects will be leukemias and lymphomata. The March 6 topic will be gynecologic malignancies. Cancer of the gastrointestinal tract will be reviewed on March 27, and pediatric malignancies on April 24. The final program, on May 8, will focus on malignancies of the head and neck. For registration or more details, write to Dr. John D. Coleman, Regional Medical Program, 7 Glenwood Avenue, East Orange, New Jersey 07017.

Clinical Application Of Basic Sciences

The Burlington County Memorial Hospital series on clinical application of the basic

sciences has arranged the following programs for February:

- February 4 Immunology and Neoplastic Diseases
- February 11 Fibrinolysis and Fibrinolytic Agents
- February 18 Emotional and Psycho-Social Maturation
- February 25 Physiology of Puberty and Psycho-Sexual Maturation

All sessions are held in the Common Room of the T. J. Summey Building at the hospital and convene promptly at 3:30. One and a half credits per session are allowed by the American Academy of General Practice. For further information, contact the Department of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Rehabilitation In Lung Diseases

New York University offers a full-time course on "Rehabilitation in Chronic Lung Diseases" March 1 and 2, 1971. This course will translate the theory and symbolic language of respiratory physiology into clear, clinical language of use to the practicing physician. It will emphasize the practical aspects of pulmonary function testing and the clinical rationale of physical therapeutic measures in rehabilitating patients ill with such lung diseases as chronic bronchitis and chronic pulmonary emphysema, and with neuromuscular and skeletal disorders of the thorax. Tuition is \$100 and registration is limited. For an application please write to Dr. Edward H. Bergofsky, NYU Institute of Rehabilitation Medicine, 400 East 34th Street, New York 10016.

Cryosurgery Meeting

The Society of Cryosurgery will hold a meeting March 1 to March 6, 1971 at the Diplomat Hotel and Country Club in Hollywood,

Florida. An outstanding group of speakers will present papers on all aspects of cryosurgery. Dr. Richard Lillehei, Department of Surgery, University of Minnesota, will preside.

Each section will be headed by an acknowledged leader in his field. Because of great demand for a longer session, the *Ophthalmology* section will hold a three-day meeting March 4, 5, and 6.

For further information, please write to Mary Trueblood, Society for Cryosurgery, 30 North Michigan Avenue, Chicago, Illinois 60602.

Gynecologic Endoscopy

Announcement is made of three courses in gynecologic endoscopy to be offered at the Saint Barnabas Medical Center in Livingston on March 4 and 5, on June 3 and 4, and on December 2 and 3; all dates are 1971. This is an intensive course in which the physicians themselves will have opportunity to perform culdoscopies and peritoneoscopies, as well as to become familiar with the latest technics and interpretation of findings. The registration fee of \$200 includes two luncheons. For further information, write to James L. Breen, M.D., Director of the Department of Obstetrics and Gynecology, Saint Barnabas Medical Center, Old Short Hills Road, Livingston, New Jersey 07039.

AAGP Convention

March 17 to 21, 1971 are the dates and the Host Farms, Lancaster, Pennsylvania, is the place for the next convention and graduate education course of the American Academy of General Practice. This year's meeting will include courses in sigmoidoscopy, intrauterine contraceptive devices, pediatrics, cardiac arrhythmias, and gastroenterology. For further details write to the Executive Secretary, Mr. Arthur Ellenberger, 144 South Harrison Street, East Orange 07018.

Otolaryngology: 1971

The Department of Otolaryngology of Jefferson Medical College (Thomas Jefferson University, Philadelphia) announces a graduate symposium April 1 and April 2, 1971. Theme will be "Therapy in Otolaryngology—1971." It focuses on both medical and surgical treatment and includes otology, rhinology, sinus disease, allergy, head and neck cancer, trauma, and maxillofacial surgery. Registration fee of \$50 for practicing physicians and \$10 for residents will include lunches on both days, and a dinner meeting. For further information, write to William H. Baltzell, M.D., Department of Otolaryngology, Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

Course In The Vestibular Apparatus

A part-time, three-day course will be given from 9 a.m. to 5 p.m., Monday and Tuesday, May 3 and 4, and 9 a.m. to noon on Wednesday, May 5, 1971. This course deals with the anatomic and physiologic aspects of vestibular testing and stresses the practical application of these tests. Attention is paid to the evaluation and assessment of test results as part of the audio-logic and otoneurologic workup. The program is given under the direction of Francis M. Fodor, M.D., Director of Otolaryngology at the New York Eye and Ear Infirmary, where the course is given. Tuition is \$100. For registration or more details, write to Post-Graduate Institute, New York Eye and Ear Infirmary, 310 East Fourteenth Street, New York 10003.

History Of Medicine Journal Available

A new journal, *History of Medicine*, a quarterly publication printed in Great Britain, is now available to American physicians. The annual subscription is \$6 including postage. Your attention is called to the advertisement inside the back cover of the December 1970 issue of *The Journal*, MSNJ.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1971

January

- 6 Camden County Medical Society
Tavistock Country Club
Haddonfield
- 6, 13, Columbus Hospital
- 20, 27 Hospital Annex
Simplified ECG for the family physician
- 6, 13, Academy of Medicine of New Jersey
- 20, 27 St. Michael's Medical Center, Newark
Cardiology
- 6, 13, Muhlenberg Hospital
- 20, 27 Plainfield
Gastroenterology
- 7 Burlington County Memorial Hospital
Mount Holly
Lymphoid-Immune System
- 10 Bergen County Medical Society
- 10 Gloucester County Medical Society
- 10 TB-Respiratory Disease Association of
Southern New Jersey
- 10 Ocean County Medical Society
- 10 Middlesex County Medical Society
- 10 Warren County Medical Society
- 13 Academy of Medicine of New Jersey
State Hospital, Trenton
Drug Addiction
- 14 Burlington County Memorial Hospital
Mount Holly
Immunity, Genetics, and Virus Infections
- 16 New Jersey Regional Medical Program
NJCMD, Newark
Breast Cancer
- 19 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Leukemia and Lymphoma
- 20 Academy of Medicine of New Jersey
VA Hospital, Lyons
Emergency Room Care

- 21 Burlington County Memorial Hospital
Mount Holly
Immune Mechanisms in Lupus Erythematosus
and Rheumatoid Variants
- 23 New Jersey Regional Medical Program
NJCMD, Newark
Gynecological Cancer
- 28 Burlington County Memorial Hospital
Mount Holly
Immunologic Abnormalities in Neurologic Dis-
eases
- 30 New Jersey Regional Medical Program
NJCMD, Newark
Lung Cancer

February

- 2 Hudson County Medical Society
- 3 Academy of Medicine of New Jersey
Runnells Hospital, Berkeley Heights
Diagnosis and Treatment of Shock
- 3 Muhlenberg Hospital
Plainfield
Gastroenterology
- 3 Academy of Medicine of New Jersey
and St. Michael's Medical Center
- 10 Newark
Cineangiography
- 3, 10, Columbus Hospital
- 17, 24 Hospital Annex, Newark
Simplified ECG for the family physician
- 3, 10, Muhlenberg Hospital
- 17, 24 Plainfield
Neurology
- 4 Burlington County Memorial Hospital
Mount Holly
Immunology and Neoplastic Diseases
- 4 Saint Barnabas Medical Center,
Livingston
Hormonal Cytology
- 9 Academy of Medicine of New Jersey
Morristown Memorial Hospital

- Morristown
Antibiotics
- 11 **Burlington County Memorial Hospital**
Mount Holly
Fibrinolysis and Fibrinolytic Agents
- 16 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Diagnosis and Treatment of Shock
- 18 **Burlington County Memorial Hospital**
Mount Holly
Emotional and Psycho-social Maturation
- 24 **Academy of Medicine of New Jersey**
Albert Einstein Medical Center,
Newark
Pediatric Renal Disease
- 25 **Burlington County Memorial Hospital**
Mount Holly
Physiology of Puberty and Psycho-sexual Ma-
turation
- March**
- 2 **Hudson County Medical Society**
- 2 **Academy of Medicine of New Jersey**
Section on Dentistry
Academy of Medicine Offices
Bloomfield
Saliva in Reference to Systemic Disease
- 3 **Camden County Medical Society**
Tavistock Country Club
Haddonfield
- 3, 10, **Muhlenberg Hospital**
- 17, 24 **Plainfield**
Neurology
- 3, 10, **Columbus Hospital**
- 17, 24, **Hospital Annex, Newark**
- 31 **Simplified ECG for the family physician**
- 4 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Drug Addiction
- 4 **Burlington County Memorial Hospital**
Mount Holly
Management of Infertile Couple
- 4 **Academy of Medicine of New Jersey**
National Institutes of Health
Bethesda, Maryland
Clinical Infectious Diseases
- 4 **Saint Barnabas Medical Center**
Livingston
Multiparous Trap
- 4 **St. Barnabas Medical Center**
Livingston
- 5 **Gynecological Endoscopy**
- 8 **Academy of Medicine of New Jersey**
Paul Kimball Hospital
Lakewood
Drug Addiction
- 9 **Bergen County Medical Center**
- 9 **TB-Respiratory Disease Association of**
Southern New Jersey
- 9 **Middlesex County Medical Society**
- 10 **Academy of Medicine of New Jersey**
Overlook Hospital, Summit
Respiratory Failure
- 11 **Burlington County Memorial Hospital**
Mount Holly
Sexual Problems Seen in Office Practice
- 16 **Academy of Medicine of New Jersey**
Overlook Hospital, Summit
Renal Failure
- 16 **Academy of Medicine of New Jersey**
Burlington County Memorial Hospital
Mount Holly
Generation Gap in Medicine
- 17 **Academy of Medicine of New Jersey**
Atlantic City Hospital
Emergency Room Care
- 17 **Academy of Medicine of New Jersey**
Cornell School of Medicine, New York
Cardiac Drugs
- 18 **Morris County Medical Society**
- 18 **Gloucester County Medical Society**
- 18 **Burlington County Memorial Hospital**
Mount Holly
Biochemical Parameters of Aging
- 24 **Academy of Medicine of New Jersey**
Dental Section
Veterans Hospital, East Orange
Symposium on Intact Dentition
- 24 **Academy of Medicine of New Jersey**
Massachusetts General Hospital, Boston
Gastrointestinal Disease

- | | |
|--|---|
| <p>25 Burlington County Memorial Hospital
Mount Holly
Hyperlipoproteinemias</p> <p>29 Cape May County Society</p> <p>31 Academy of Medicine of New Jersey
Cornell Medical Center, New York
Heart Surgery</p> <p>31 Academy of Medicine of New Jersey
Hoffmann-LaRoche, Nutley
Symposium—Controversy in Medicine</p> <p>April</p> <p>1 Burlington County Memorial Hospital
Mount Holly
Pre-diabetic Syndrome</p> <p>5 Academy of Medicine of New Jersey
Greenville Hospital, Jersey City
Emergency Room Care</p> <p>6 Hudson County Medical Society</p> <p>7 Academy of Medicine of New Jersey
and Holy Name Hospital, Teaneck
14 Uremia</p> <p>7, 14, Columbus Hospital
21, 28 Hospital Annex, Newark
Simplified ECG for the family physician</p> <p>8 Burlington County Memorial Hospital
Mount Holly
Recent Advances in Diabetes Mellitus</p> <p>8 Saint Barnabas Medical Center
Livingston
Irradiation Therapy</p> <p>13 Cumberland County Medical Society</p> <p>13 Bergen County Medical Society</p> <p>13 Middlesex County Medical Society</p> <p>14 TB-Respiratory Disease Association of
Southern New Jersey</p> <p>14 Academy of Medicine of New Jersey
Runnells Hospital, Berkeley Heights
Difficult Diabetic Patient</p> <p>15 Gloucester County Medical Society</p> <p>15 Morris County Medical Society</p> | <p>15 Burlington County Memorial Hospital
Mount Holly
Management of Exogenous Obesity</p> <p>20 Warren County Medical Society</p> <p>20 Academy of Medicine of New Jersey
Englewood Hospital, Englewood
Leukemia and Lymphoma</p> <p>21 Academy of Medicine of New Jersey
Yale—New Haven Medical Center
New Haven, Connecticut
Endocrinology</p> <p>21 Academy of Medicine of New Jersey
Saint Michael's Medical Center, Newark
Cardiovascular Workshop</p> <p>22 Burlington County Memorial Hospital
Mount Holly
Hypercalcemia</p> <p>28 Academy of Medicine of New Jersey
St. Barnabas Medical Center
Livingston
Pre and Post Operative Care</p> <p>29 Burlington County Memorial Hospital
Mount Holly
Interservice Seminar</p> <p>May</p> <p>4 Academy of Medicine of New Jersey
Morristown Memorial Hospital
Morristown
Diagnosis and Treatment of Shock</p> <p>4 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Drug Addiction</p> <p>5 Camden County Medical Society
Tavistock Country Club
Haddonfield</p> <p>5, 12, Columbus Hospital
19 Hospital Annex, Newark
Simplified ECG for the family physician</p> <p>6 Saint Barnabas Medical Center
Livingston
Familia Toxemia</p> <p>6 Burlington County Memorial Hospital
Mount Holly
Drug Abuse</p> |
|--|---|

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OBITUARIES

Dr. Anthony F. Caprio

Anthony F. Caprio, M.D., died at the age of 65 on November 11, 1970. Dr. Caprio was in the class of 1934 at the Medical School of the University of Naples. He was a widely respected family doctor who served the people of northern Essex and southern Passaic Counties for many years. Dr. Caprio was affiliated with the Clara Maass Hospital in Belleville and St. Michael's Hospital in Newark. He was a member of our Essex County Medical Society.

Dr. Henry DeVincentis

One of our state's best known orthopedic surgeons, Henry DeVincentis, M.D., died on September 9, 1970. Born in 1900, he won his M.D. at the Medical School of the University of Maryland in 1926. He served at St. Mary's Hospital in Orange, at the Crippled Children's Hospital in Newark, at St. Barnabas Medical Center in Livingston, and was also affiliated with the Martland Hospital in Newark and the Hospital Center at Orange. He was active in committee work for our Essex County Medical Society.

Dr. John R. Mabee

At the untimely age of 53, John R. Mabee, M.D., of Little Falls, died on October 16, 1970. Dr. Mabee was a general practitioner who was graduated from the Boston University Medical School in 1942. He was a member of the Passaic County Medical Society and affiliated with the Paterson General Hospital.

Dr. Albert F. Monte

For thirty years the Harrington Park area in Bergen County has been proud of Albert F. Monte, M.D. He was a general practitioner in the ancient (and now revived) concept of the "family doctor." He was associate obstetrician to the Pascack Valley Hospital in

Westwood. Dr. Monte was born in 1913, and received his M.D. degree at Long Island in 1939. And on November 12, 1970, Dr. Monte died at the age of 57.

Dr. Elizabeth Nesbitt

One of our State's pioneer women physicians, Elizabeth Nesbitt, M.D., died on October 21, 1970. Born in 1886, she retired at the age of 70, in 1956. She was, for many years, active in the affairs of the American Women's Medical Association. Dr. Nesbitt won her M.D. at the University of Toronto in 1929, and was 84 years old at the time of her death.

Dr. Morris M. Osher

On November 26, 1970, at the age of 63, Morris M. Osher, M.D., a general practitioner from Fanwood, died suddenly. Dr. Osher was active in the American Academy of General Practice and was, indeed, the senior attending in general practice at the Muhlenberg Hospital in Plainfield. He was a member of our Union County Medical Society.

Dr. Louis G. Shapiro

In 1963, one of our Golden Merit Award laureates was Louis Gershon Shapiro, M.D. Born in 1892, he was in the class of 1913 at the Columbia University College of Physicians and Surgeons. He was an early diplomate of the American Board of Internal Medicine and served for many years as an attending physician on the staff of the Barnert Memorial Hospital in Paterson. Dr. Shapiro retired from active practice three years ago, and died on November 12, 1970.

Dr. Charlotte Warner

At the untimely age of 58, Charlotte R. Warner, M.D., died on October 18, 1970. Born in 1911, she was graduated at the age of 25 from the Women's Medical College of Philadelphia. Dr. Warner was affiliated with the Englewood Hospital and was a well-known Bergen County general practitioner for two decades.

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BOOK REVIEWS

Big Fleas Have Little Fleas. Robert Hegner, Ph.D.
New York, 1968, Dover Publications. Pp. 285. (Soft-
back \$2)

In 1938, Dr. Hegner (chairman of zoology at Johns Hopkins) wrote *Who's Who among the Protozoa*. It is here reprinted with a new introduction. The book includes several hundred line drawings, most of them more like cartoons. The subject is one about which most medical clinicians know very little. Yet human beings are richly infested with all sorts of protozoa. Dr. Hegner here makes the story an interesting one, lightened by many witticisms, humorous turns of phrase, and vivid analogies. Thus, the reader is told that he is being taken on a journey through the native haunts of the protozoa "among the muscle fibers, in the swift-flowing blood stream, in the midst of champing teeth, and within the peristaltic intestine." The author points out that in terms of ability to survive under difficulties, protozoa are more successful than human beings. ("A minute particle of animated jelly like a protozoon can maintain itself in the struggle for existence in competition with the larger animals.")

Clinically, the study of protozoology has paid off in the control of malaria, amebic dysentery, trypanosomiasis, and kala azar. Dr. Hegner even reviews the sex life of protozoa, which is of interest not only to other protozoa, but to students of human genetics. Parasites need the right conditions of temperature, moisture, and food—and for them, the human body is a veritable garden. Before you have finished reading this book, you will see yourself as a "banquet hall for the entertainment of amebas." I just learned here that the flavoring of a steak is due largely to the ciliates digested by the cattle!

The book includes a glossary, and some interesting data about the history of our knowledge of malaria, leishmaniasis, and other parasite-caused diseases. This volume will not help you in your daily practice, but it will give an added dimension in your understanding of the cycle of life.

VICTOR HUBERMAN, M.D.

Disability in Antiquity. Farheed Haï, Ph.D., New York, 1970, Philosophical Library. Pp. 188. (\$6.50)

The "antiquity" referred to in this book title is the period from A.D. 600 to A.D. 1300, and the only area covered is the Moslem world of the Near East. The text is a consideration of persons who were deprived of the use of a faculty or organ, with many stories as to how they got that way. The commonest disability in that place and period was blindness. Some was due to trachoma, some to gonorrheal conjunctivitis, some to infectious ophthalmitis; but much of it was due to corporal punishment. Apparently it was a common practice for Arab potentates to discipline their opponents by blinding them. It was also common to punish thieves and other miscreants by amputating

a hand for each offense. Epilepsy and psychoses were less common causes of disability. References are also made to disability caused by the plague and by rabies. In general, the material is presented as a series of anecdotes. There is very little discussion of treatment, public health controls, or of efforts to rehabilitate the disabled. Perhaps this was too much to expect for those early centuries. The text is enriched by 163 footnotes, which is a valiant effort to exhaust the subject, without exhausting the reader.

ABRAHAM LEEF, M.D.

The Adolescent Patient. William A. Daniel, Jr., M.D.
St. Louis, 1970, Mosby. Pp. 444. 76 Illustrations.
(\$20.50)

This book is either too long or too short. If the reader expects to find only conditions affecting the adolescent, he gets much more than he cares to know (six whole pages, complete with food value tables on making up a diabetic diet). On the other hand, if he is looking for every condition which could affect the adolescent he will have to look further (not even a mention of ulcerative colitis or Crohn's disease).

I would have liked more illustrations—for example, a few samples of normal adolescent growth curves, or a picture of a patient in a Milwaukee brace included in the several pages of discussion about it. Four full pages of illustrations are devoted to specific chromosome arrangements in rare genetic disorders—not exactly the kind of information the practicing physician will remember the next time he looks through his electron microscope.

The last chapter on the parents of the adolescent is one of the best I have ever read. It should be read by everyone who has anything to do with children and/or parents.

LILLIAN M. ROSENBERG, M.D.

Mutation As A Cellular Process (Ciba Foundation).
Edited by G. E. W. Wolstenholme and Maeve
O'Connor. Baltimore, 1970, Williams and Wilkins. Pp.
244. Illustrated. (Price not stated)

This additional volume in the scholarly Ciba Symposium series concerns itself with mutation as a cellular process and "not just an isolated event, a quantum event or a simple chemical reaction." Mutation is a complex process in which cellular metabolism is intimately involved. This concept offers rational unity to the problems of cellular mutation whether approached from the view of the physicist, the chemist, or the molecular biologist. The participants are from many countries and represent the three disciplines mentioned in the preceding sentence.

In the chairman's opening remarks it is stated that in cellular mutation three main steps must be recognized: (1) initiation, (2) fixation (self-replicating), and (3) detection, translation, or expression. Included are 13 papers which discuss these aspects of mutation as it can be induced by various chemicals or differing forms of radiant energy on bacteriophages, bacteria, and drosophila. This is a complex subject and the book requires reading of a contemplative type. It should be rewarding reading for geneticists, molecular biologists, and biochemists, who are working in the area of mutation in cells. It is further recommended for all biologic scientists who are interested in recent trends in this important field.

HUGH F. LUDDECKE, M.D.

Pathology Annual: 1970. Sheldon C. Sommers, M.D., Editor. New York, 1970, Appleton-Century-Crofts. Pp. 436. Illustrated. (\$15)

This hard cover book contains 15 well-written chapters of original work by 20 authors. References are as late as 1968. This excellent reference book for the pathology library, in combination with previous yearly editions of this series, plus the Year Books of Pathology, will keep readers up to date in work in his field even if some of the tools are not yet at his disposal. This edition includes material on ultra structure, practical diagnostic problems, and technical procedures.

Ultra structure of normal and neoplastic human prostate, adrenal medullary tumors, and acute inflammatory reaction are presented in a sophisticated way. As the electron microscope becomes more available to the practicing pathologist these considerations will become more valuable in diagnostic pathology.

Practical diagnostic considerations include: pathogenicity of the antigen-antibody complex, pneumocystis carinii pneumonia, embryonal carcinoma of the testes, primary carcinoma of the liver, diagnostic problems in lymph nodes, and lupus nephritis. The illustrations are variable in photographic quality. They are excellent in the article on primary carcinoma of the liver but only fair in the chapter on lymph nodes. This is unfortunate because the latter is of more frequent interest than the former.

Technical considerations include: microdissection of normal and abnormal renal structures, tumor registries, use of polarized light in microscopy, and tissue culture of human tumors. The index is helpful and useful, especially when working with the book as part of a yearly series.

ALLAN LAZAR, M.D.

Microneurosurgery. Robert W. Rand, M.D. Saint Louis, 1969, Mosby. (\$25)

This textbook explicitly describes the new technics of neurosurgery with the use of the microscope. This development comes largely from the otologist and the ophthalmologist who, with their microsurgical instruments, have actually opened the way in neurosurgical procedures. Prime purpose of the microscope is to permit better visualization of tissue which was not clearly evident before. Therefore, the reconstruction is more accurate, the neurovascular surgical procedures are more precise and the results are less traumatic.

Looking through the microscope is somewhat akin, I think, to when man first looked through the telescope at the moon. Structures that we could barely see are apparent with the use of this microscope. Although it does require specific training and instruction, its applications are quite shocking. The acoustic tumors and brain tumors which were attacked before appear very gross when done and compared with the use of the microscope and microinstruments. Microsurgery also permits the reconstruction of peripheral nerves and cerebral aneurysms. Tiny blood vessels of the brain such as the middle cerebral (which is only 2 to 3 mm. in size) are now visible under the microscope and, therefore, are surgically attackable. Malformations of the spinal cord now are corrected under microscope with better results.

This textbook is well organized, showing and indicating the applications, the use of the surgical microscope and the instruments required. There is a review of the

neuroanatomy and the results of some of the leaders in this field, the technics for attacking the pituitary and other tumors of the brain. The photographic reproductions are excellent and some of them are in color. This book is well worthwhile purchasing for all neurosurgeons and for general surgeons who contemplate doing microvascular surgery.

ARTHUR WINTER, M.D.

Effective Utilization of Psychiatric Evidence. New York, 1970, Practising Law Institute. Pp. 590. (\$15)

Assembled here, between hard covers, is a set of 28 reprints on several aspects of forensic psychiatry—personal injury claims, criminal responsibility, competence to stand trial, and the psychiatrist as a witness. There is nothing about testamentary capacity, nor about malpractice claims against psychiatrists. At least I cannot find any such reprints here and since the book has no index, there would be no way of tracking down this material even if it were included. I do find excellent thought-provoking papers by Watson, Pollack, Diamond, and Modlin, all previously published—the paper on the psychiatrist as an expert witness (by Diamond and Louisell) for instance, was first published in 1965. Also included is Dershowitz's brilliant if somewhat disturbing paper, "The Knife That Cuts Both Ways," which is uncomfortably critical about the role of the psychiatrist in commitment procedures.

The publishers took photocopies of manuscripts and published articles and simply bound them together. Thus there is an unevenness about the printing, and a lack of any editorial comment that might tie the material together. Especially unfortunate is the complete lack of an index, which makes the volume almost useless for reference purposes.

There is still room for a practical, well-indexed reference volume on the effective use of psychiatric testimony. The price—\$15—for a collection of reprints seems a bit high even in these inflationary days.

HENRY A. DAVIDSON, M.D.

Instructional Course Lectures, (Vol. 19). American Academy of Orthopaedic Surgeons. St. Louis, 1970, Mosby. Pp. 236. Illustrated. \$19.50

The return of the "Instructional Course Lectures of the American Academy of Orthopaedic Surgeons" in volume form after an absence of almost ten years will be appreciated by orthopedic surgeons everywhere. The chance to review courses taken at the annual Academy meetings and to study the subject matter which one was unable to take is a most welcome one.

Each of the 13 courses presented is by a different group of authors so the format and quality of the discussions vary. Most of them, however, have been presented with modifications over a series of years and they are well organized, well illustrated, and well presented. Almost all of these articles will be of interest so that this series belongs in your permanent library. For the non-orthopedist, only certain of the articles may be of interest and this series will primarily be a reference source.

Particularly worthwhile for the non-orthopedist are the papers on fractures in children; orthopedic management of muscular dystrophy; clinical applications of electric diagnostic studies; the incidence and prevention of thrombo embolic disease; and clinical and pathologic studies of fat embolism.

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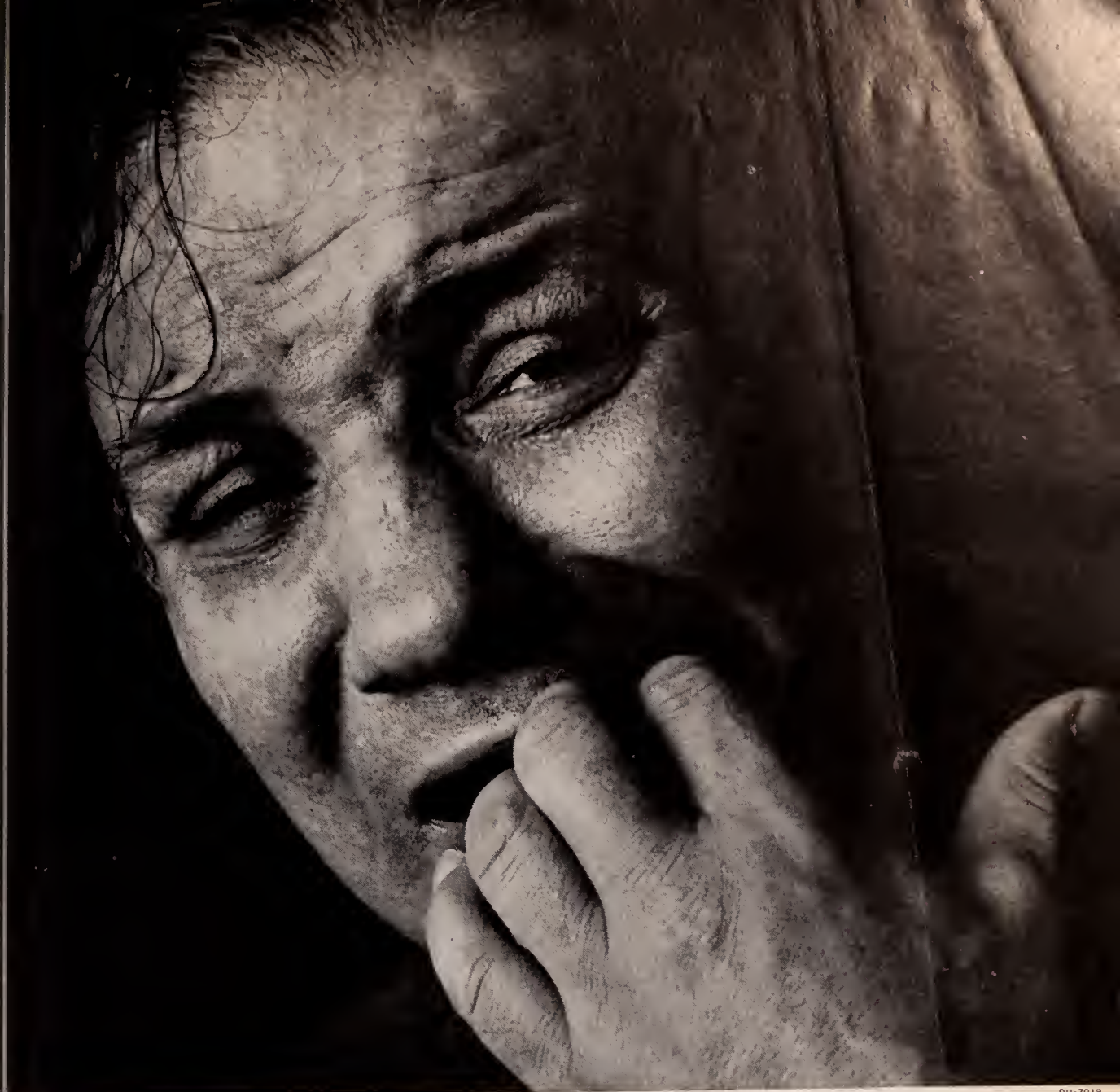
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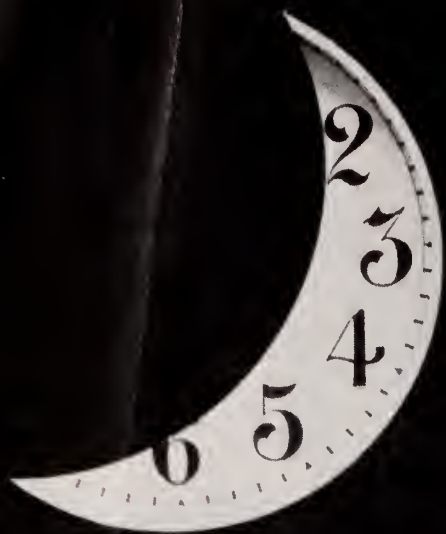
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Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

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when the diagnosis is depression

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EDITORIALS

Your State Society Dues

Of the 51 state medical societies (including the District of Columbia), 14 have annual dues of \$100 or more. The blue ribbon winners in this derby are: Minnesota (\$100), Arizona (\$105), New Mexico (\$105), Illinois (\$105), Idaho (\$120), Michigan (\$125), Oregon (\$125), North Dakota (\$125), South Dakota (\$125), Hawaii (\$140), North Carolina (\$145), Wisconsin (\$145), Iowa (\$150), and Alaska (\$200).

Then there are 32 state societies with annual dues between \$60 and \$90, and, finally, only 5 with dues under \$60. These five are Massachusetts (\$35), Connecticut (\$50), Ohio (\$50), New Jersey (\$55), and Texas (\$55). In other words, if you list the state medical societies in order, according to amount of dues, New Jersey is 48th from the top—\$55 a year in dues, compared with the median at \$85.

We refrain from comment.

Doctor's Assistant And The Assistant Doctor

Last month in this *Journal*, we published a thoughtful article by Dr. Henry A. Brodtkin on "family practice." One of Dr. Brodtkin's points was that we should not try to solve the doctor-shortage problem by creating a new corps of licensed assistants who would have a much shorter educational and training program than the M.D. However, in November 1970, the National Academy of Sciences suggested precisely that. Their plan would be to create three kinds of assistants. As reported in the November 30, 1970, *Modern Medicine*, this, they said, "would be the fastest way to relieve the medical manpower shortage." The bottom level in this three-tiered hierarchy of assistants would be, in the words of the Na-

tional Academy of Sciences, "to medicine what the practical nurse is to nursing." At the second level, the "assistant" would be skilled in one type of procedure or even "one type of clinical specialty." The top level would be a "physician associate." The "associate," under an MD's supervision, would be permitted to do "diagnostic and therapeutic work." How much education would he have to have? A high school diploma? That's what the National Academy of Sciences suggests.

In this connection, the NAS has asked the AMA "to cooperate in eliminating legal barriers and in setting educational standards for certification of physicians' assistants." It is interesting that NAS recommends not licensure but "certification."

The problem was seen in a different focus when the National Congress on Health Manpower met in December 1970 under AMA auspices. They were more concerned with defining the kinds of functions that an MD could delegate than they were with creating a new bevy of legally certified assistants.

Underlying all suggestions for new "medical assistant" categories is the assumption that the practice of medicine is a craft that can be learned by a kind of vocational training, the way a young man can be taught to repair television sets or set permanent waves in a beauty parlor. This delusion may be, in part, our own fault. That is, we have made it seem as if computers could give us a diagnosis by one kind of programing and then print out the proper treatment by pushing some additional buttons. Maybe we have become so enchanted with the idea that we are vendors of "medical services" that we have forgotten that we are also standbys for people in trouble. Compassion can't be punched into a computer. The medical school isn't (or should not be) a vocational school. The decision as to removing a peptic ulcer surgically or treating it medically has to be made by a physician who cannot only recite the doses of the gels and the indications for surgery, but who also has a well rounded understanding

of the physiology of digestion, the pharmacology of antacids, the complications of surgery, the vagaries of the human personality, and the anatomy of the gastrointestinal tract.

Medicine has reached its present dignity after a thousand years of struggle. Barbers are fine people and we need them. But they are not surgeons in spite of the honorable barber-surgeon tradition (memorialized by the red and white striped pole). We need pharmacists, certainly, and we need trainers and coaches for football teams and for boxers. But they are not MDs and any blurring of the line would be a reactionary move back to the *feldsher* or to the barber-surgeon. Let's face it. The road to medical mastery is long and arduous and there are no short cuts, bypasses, or backdoor points of entry.

It Doesn't Always Come Up Roses*

The discovery of each new substance with biologic activity will be accompanied by some biologic threat. Thus, the new substance may be an insecticide which damages birds' eggs, or new antibiotics which might lead to the development of threatening mutant strains of bacteria.

Every time the clinician develops a new artificial situation which markedly affects patients, search should be made for adverse effects. In some instances the adverse effects may not only threaten a patient, but his physician as well. An example is the danger associated with renal dialysis and the secondary effects of immunosuppression for the patient and indirectly the attending staff. Dangers to the patient include electrolyte abnormalities, peculiar alterations of hormonal balances, obscure adverse effects on the hematologic system, susceptibility to infection, and even psychologic effects which are difficult to measure. An illustration of the danger to patients

treated by immunosuppression is the threat of undetected cancer cells in the transplanted kidney and the development of new cancers from the patient's tissues. As immunosuppression by chemicals and antilymphocyte globulin reduces the natural surveillance mechanisms—probably lymphocytes—abnormal cells can gain a foothold, grow, and then generate their own antigenic material which may further neutralize defense mechanisms. There are reports of the development of 25 malignancies in relatively young patients treated with immunosuppression measures for a few years. One might expect that other diseases in which cellular immunity plays a major role will also develop in such patients.

Outbreaks of hepatitis are common in patients undergoing renal dialysis. They are exposed to multiple blood transfusions and have a reduction of normal defenses. The course of this disease is not as severe in patients under immunosuppression, probably because the antibody—antigen—tissue reaction is also suppressed.

These outbreaks provide a threat to staff members. The number of nurses and physicians who have developed severe hepatitis has become a problem of major importance. It is clear that immediate steps must be taken to protect the staff members of such units. The unit should be separated from hospital activities and appropriate warnings of "Biological Hazard" be posted. Apparently the prophylactic treatment of the staff members of dialysis units with gamma globulin has not been effective, but a vigorous assessment of the dangers of this prophylactic treatment has not been made. It would seem wise that all medical centers inform prospective employees in such units of the dangers associated with them and that blood samples be obtained before employment so that the levels of the AU-SH antigen be detected. Perhaps only persons with positive AU-SH antigenicity should be employed.

These episodes remind us that there is a biologic price to pay for each new development of a biologic active substance or procedure.

*Reprinted from the October 1, 1970 *New York State Journal of Medicine*

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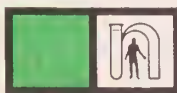
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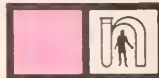
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Specific therapy for night leg cramps

ORIGINAL ARTICLES

Here described is an association between mongolism and renal medullary lesions, never previously reported.

Renal Papillary Fibrosis*

Associated With Cardiac Tamponade In A Patient With Down's Syndrome

Tetsuo Shimamura, M.D./New Brunswick

Some diseases involving the renal medulla in man terminate in uremia. Others lead to more protracted renal functional derangement. For example, pyelonephritis and diabetes mellitus are not infrequently followed by renal medullary necrosis.^{1, 2} Apart from the acute lesion, renal medullary changes are apparent in many patients with these diseases. Few aged males are free from prostatic hypertrophy which often causes urinary obstruction. This can cause renal functional impairment such as polyuria,^{3, 4} presumably due to the loss of concentrating ability of the renal medulla. The association of phenacetin intake and renal medullary necrosis has long been known,^{5, 6} particularly in patients with rheumatoid arthritis.⁷ A renal medullary lesion can be due to sickle cell anemia.⁸ A renal concentrating defect occurs in malnutrition, and it is thought that the decreased urea concentration in the renal medulla is the cause of the defect, although no morphological alteration of the medulla associated with it has been described.⁹ Various experimental means,¹⁰⁻²¹ including renal vein constriction²² also induce renal medullary necrosis.

The author has observed an extensive medullary fibrosis occurring in a patient with Down's syndrome who died of severe constrictive pericarditis. There were no known clinical findings of diabetes mellitus, pyelonephritis, urinary obstruction, sickle cell anemia, or phenacetin abuse. At autopsy, both renal veins were extremely dilated, reaching the size of

an adult inferior vena cava, due to severe constrictive heart failure secondary to the cardiac tamponade. The situation observed in this case closely simulates an experimental condition of renal medullary lesion due to renal vein constriction. Although the exact cause of the renal medullary fibrosis in this case remains uncertain, the finding is unique and worthy of record.



Figure 1—An x-ray film of the chest demonstrates a total opacity of the left lung field. The mediastinum is shifted to the right.

* This work is from the Rutgers Medical School, where Dr. Shimamura is Assistant Professor of Pathology. Reprint requests should be addressed to him at Rutgers Medical School, New Brunswick, New Jersey 08903

A nineteen-year-old male with Down's syndrome (mongolism), a resident of the Woodbridge State School for the retarded children in New Jersey, was coughing and reported as "not feeling well." He was not in acute distress. He had no cyanosis. Dullness was present at the base of the left chest wall and tubular breath sounds were heard over the left upper chest. He was hospitalized with a diagnosis of bronchopneumonia of the left lung. A shadow (thought to be a pleural effusion and pulmonary infiltrate) in the left upper lung field was present in the chest x-ray taken on admission. There was a moderate leukocytosis with a shift to the left. Sputum culture showed a heavy growth of Gram-negative bacilli. The patient was treated with Keflin® and Vibromycine® after sensitivity tests had been carried out. During the subsequent two weeks of the treatment, there was no fever or distress. However, there was a progressive worsening noted in the finding on later chest x-ray films (Figure 1). A consultant diagnosed "total collapse of the left lung" and scheduled a bronchoscopy. The patient appeared tired and started to have a spiking temperature. On the 19th hospital day, shortness of breath developed, and he was placed in an oxygen tent. On the 20th hospital day, severe respiratory distress unresponsive to administration of aminophyllin and epinephrine developed. The patient died before having the bronchoscopic examination.

Autopsy: The patient was poorly developed with immature secondary sexual characteristics. Typical somatic findings of Down's syndrome were present. Upon opening the thorax we noted that the pericardial sac was distended with a huge amount of serosanguinous fluid which measured at least 1100 milliliters. The distended sac almost completely occupied the entire left pleural cavity, compressing the atelectatic left lung to the size of an adult fist. The entire visceral and parietal epicardial surfaces were covered with a grey, lusterless, fibrinoid material. The right lung was voluminous, congested, and edematous with an increased consistency. The left lung was fibrous and atelectatic with often obliterated bronchial lumina. The superior and inferior venae cava and their major tributaries were filled with blood and markedly distended. The renal veins and their tributaries were distended with blood, and the diameter of the renal veins had reached the size of an adult inferior vena cava. The liver had a

typical nutmeg appearance with a blunted margin. The right kidney weighed 90 Grams and the left, 120 Grams. Kidneys revealed no remarkable abnormality at fresh state, but distinct grey discoloration uniformly involving all of the papillae became evident after formalin fixation (Figure 2). Each adrenal gland weighed 4 Grams and showed a loss of deep orange color of the usual adrenal cortices. The thymus weighed 19 Grams and was fleshy in appearance. The cervical, mediastinal, para-aortic, iliac, and mesenteric lymph nodes were moderately enlarged. The rest of the findings appeared irrelevant to this report.

Section of the heart revealed a thick layer of epicardial granulation tissue with irregular deposits of fibrinous material. The right lung contained edema fluid in the alveolar spaces and had a non-specific mixed cell infiltration in the alveolar walls and lumina. Pulmonary vessels showed scattered recent intra-alveolar hemorrhage. The left lung was atelectatic with acute and chronic inflammation involving alveoli, bronchioles, and bronchial and vascular walls. Massive foamy histiocytes and scattered deposits of fibrin were seen in the completely distorted pulmonary parenchyma. The liver showed atrophy to virtual necrosis of hepatocytes in the centrilobular areas. The central veins and sinusoids were dilated. The renal cortical tissue was unremarkable, but there was fibrosis of all renal

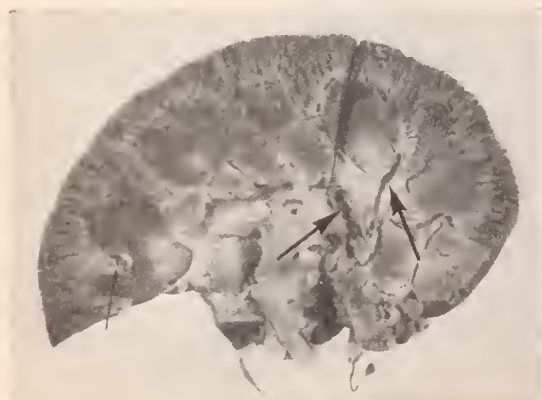


Figure 2—The grey discoloration of the renal papillae due to fibrosis is apparent. Notice a similar extent and degree of involvement of the two well-exposed papillae. The overt distension of the lumen of the draining site of interlobar veins is present (larger arrow) together with dilated arcuate veins (smaller arrow). No detectable abnormalities exist in the pelvis and calyces.

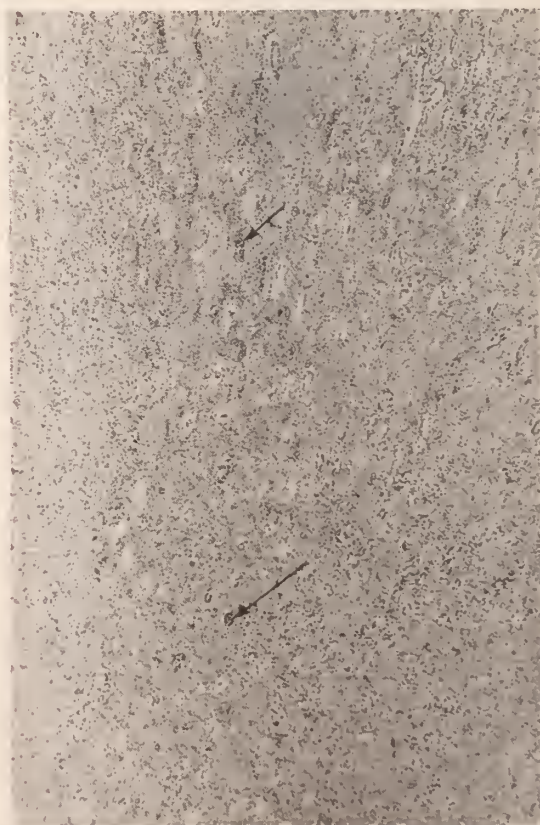


Figure 3—The interstitial fibrosis and loss of renal tubular structures are illustrated. Notice the picnotic nuclei of some of the remaining collecting tubular epithelia (longer arrow). The peritubular capillaries are engorged with erythrocytes (shorter arrow). Abundant interstitial cell nuclei are observable in the fibrosed interstitium. Hematoxylin and eosin stain. Mag. X: 33.

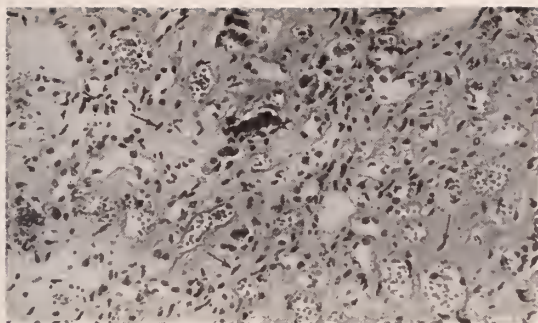


Figure 4—The loss of renal tubular structures and the interstitial fibrosis are apparent. Notice the presence of engorged capillaries and the proliferation of interstitial cells (arrow). An apparent calcium deposit is seen in some of the degenerating renal tubules. Hematoxylin and eosin stain. Mag. X: 310.

papillae of uniform degree. The loss of tubules and degeneration of the tubular epithelia were most pronounced (Figure 3). Scattered foci of apparent calcium deposits were noted in the degenerating tubular structures. (Figure 4). Less severely involved by a similar process were capillary endothelia of the papillae. The interstitial cells were practically uninvolved. They tended to proliferate in the areas of fibrosis. Scattered microscopic necrotic foci were also present in the papillae. There was a loss of adrenal cortical lipid. The thymus gland was cellular for his age. The lymph nodes and thymus gland had a proliferation of histiocytes in the dilated sinuses. There were many small lymphocytes in the lymph nodes and thymus, but the germinal centers were indistinct with scanty numbers of the blastic form of lymphocytes.

Electron microscopic findings in the renal tissue were reported as follows: The formalin-fixed renal cortex and papilla were post-fixed in one per cent veronal-buffered osmium tetroxide for one hour, dehydrated, and embedded in number one Epon-Araldite® mixture of Mollenhauer.²³ The thin sections were doubly stained

with uranyl acetate and lead citrate,²⁴ and were examined under a Zeiss EM-9A electron microscope.

Prominent fusion of the foot processes was readily observable. Scattered throughout the glomeruli were deposits in the subendothelial area and in the mesangial matrix (Figure 5). The deposit occasionally revealed regularly spaced periodic bands having intervals of 230 Angstroms (Figure 6). Collagen fibers were abundant in the interstitium of the renal papilla. In addition, numerous osmiophilic deposits, morphologically similar to those seen in the glomeruli, were present in the interstitium. Due to the poor ultrastructural preservation, detailed evaluations of cellular alterations were not attempted in this study.

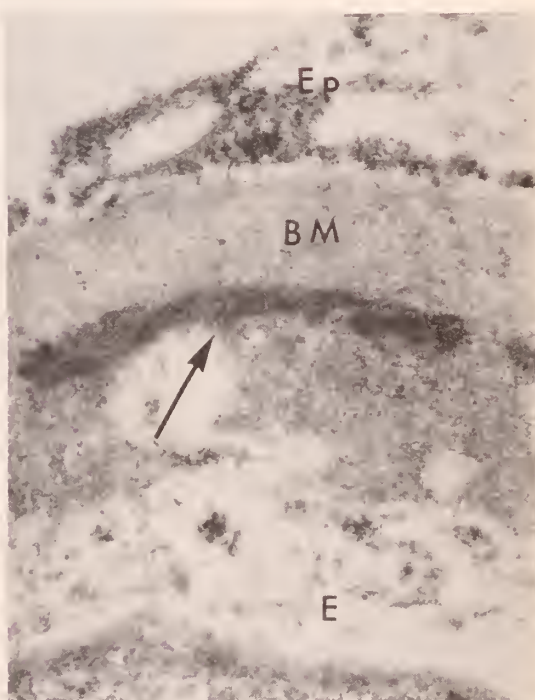


Figure 6—The osmiophilic deposit revealing periodic bands at regular intervals of 230 angstroms is illustrated (arrow). Fusion of foot processes is present. E: endothelial cell. BM: basement membrane. Ep: epithelial cell. Mag. X: 40500.

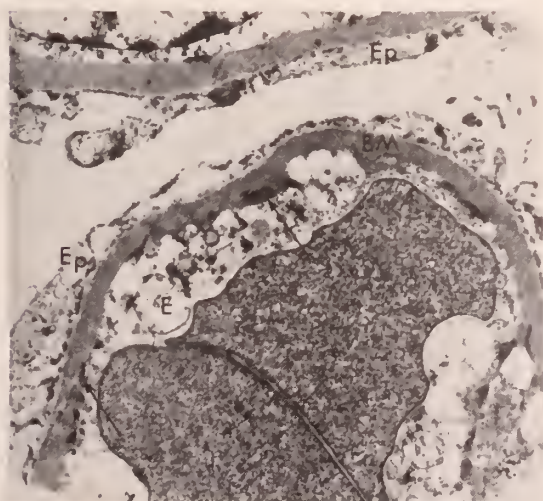


Figure 5—Numerous subendothelial osmiophilic deposits (arrow) are shown. Extensive fusion of foot processes is present E: endothelial cell. R: erythrocyte. Ep: epithelial cell. Mag X: 9900.

Despite the emerging importance of the renal medulla in urinary concentration, the structure of the medulla has only recently become the subject of serious study. Changes in structure and function which take place in the medulla both as a result of disease and as a consequence of experimentally induced lesions have almost completely escaped inquiry. Despite the common occurrence of a renal medullary lesion in various human diseases, it is rarely diagnosed.²⁵ Medullary necrosis can be produced by divergent experimental methods.

Experimental renal vein constriction produces renal papillary necrosis.²² Therefore, it is conceivable that long-standing renal vein congestion due to cardiac tamponade may induce renal papillary alteration, as was observed in this case. Experimental renal vein constriction, and similarly, renal venous congestion due to a severe and long-lasting cardiac tamponade may alter the renal medullary circulation, thereby changing the osmolarity of the medullary interstitial and intratubular fluids and the medullary oxygen tension. One can further speculate that the subsequent derangement of the metabolic process in the medulla may result from the production of a toxic metabolite which further aggravates the pathologic process in the medulla.

There appear to be four characteristic pathologic changes in this present case: (1) all of the renal papillae were involved to a similar degree of severity and extent, (2) tubular structures were most severely involved, with much less severe and patchy involvement of the capillary walls, (3) the interstitial cells were practically uninvolved; indeed, they tended to proliferate, and (4) an active, patchy, microscopic, necrotic process was noted. Differential diagnosis of the present case from the other types of papillary necrosis on morphologic basis may not be easy, for very little is known about papillary necrosis. The uniform involvement of all papillae here observed appears to be different from the diabetic or pyelonephritic medullary necrosis in which the papillae tend to be unevenly involved.²⁷ The present case revealed preservation of interstitial cells while virtually all medullary cell components appear to be involved in diabetic and pyelonephritic medullary necrosis. Whether the differences are

simply due to the difference in severity in the insult to the renal medulla is uncertain, for experimental renal vein constriction certainly can produce an overt renal medullary necrosis.²²


Obviously, other causal factors for the medullary fibrosis here need to be considered. Down's syndrome is often associated with changes in other parts of the body. I could not find any report in which an association of renal medullary lesion and Down's syndrome was described. The circulatory failure due to the cardiac tamponade may have induced a serum electrolyte imbalance and possibly even hyperaldosteronism. In rats a renal medullary lesion is known to result from potassium deficiency. Thus we had to consider the possibility that hyperaldosteronism can result from the circulatory failure incident to cardiac tamponade. The renal medullary lesion here observed differs morphologically from that caused by potassium deficiency.^{28, 29, 30} As there were no pyelonephritic changes in the kidneys, no evidence of diabetes mellitus, and there was no clinical history of phenacetin abuse, these factors can be excluded. Although the causal relationship between the severe pericarditis with cardiac tamponade and the renal medullary fibrosis still remains uncertain, the present case certainly warrants future study on this problem.

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A bibliographic list of 30 citations will be found in Dr. Shimamura's reprints.

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Expanding Aneurysm Of The Abdominal Aorta

Successful Surgery In A 96 Year-Old Patient

**Mahmud Bangash, M.D.,
Joseph J. Timmes, M.D., and
Sun Il Chang, M.D./Jersey City**

Aneurysm of the abdominal aorta is a serious condition most commonly found in patients in their seventh decade. However, a wide age range (38 to 90) has been reported. Treatment is available, regardless of the patient's age. The expanding, leaking, and rupturing forms of aneurysm represent a surgical emergency. What is indicated here is resection of the aneurysm, and replacement with a prosthesis. The emergency carries a high mortality which is directly proportional to age and other associated diseases.

We are reporting a case, perhaps the oldest patient in the literature, which illustrates the importance of the nature of the lesion and the emergency involved due to the expanding aneurysm of the abdominal aorta.

A 96 year-old woman was admitted to the Geriatric Division of the Pollak Hospital for "extended nursing care." An aneurysm of the abdominal aorta (7 by 10 centimeters) was found. Twelve hours later, she had multiple, loose bowel movements and complained of pains around the umbilicus. The pulsatile mass appeared twice its previous size. The aneurysm was tender on palpation. The abdomen in general was soft and non-rigid. A basal cell carcinoma, three centimeters in diameter, was located in the left posterior triangle of the upper neck which was mobile on the underlying structures. She had atrial fibrillations. Her blood pressure, 130/90, remained unchanged. However, her apical rate rose from 80 to 120 a minute. The blood count, blood chemistry, electrolytes, and urinalysis

* This work is from the B. S. Pollak Hospital in Jersey City, where Dr. Timmes is chief of cardio-thoracic surgery. The two other authors are residents in that specialty.

were all within normal limits. X-ray revealed a stag-horn calculus in the right kidney. This was verified by intravenous pyelogram.

Through a midline approach under general anesthesia of Inuovar® intravenous drip, the peritoneal cavity was opened. An aneurysm of the abdominal aorta was found. It was 14 by 10 centimeters. It had a soft, shining anterior wall. A fluctuation was elicited. There was no evidence of retroperitoneal hemorrhage. It was apparent that, had we delayed, rupture would have occurred anteriorly. The aneurysm began below the renal arteries, and did not involve the bifurcation. Therefore, a tubular Dacron® graft was selected as replacement prosthesis. Operative dissection was limited to retraction of the duodenum cephalad and to the right. A French catheter was encircled around the aorta, proximal to the aneurysm. This catheter was booted over one of the blades of the aortic clamp. The common iliac arteries were controlled with umbilical tapes. Heparin®, totalling 30 milligrams, was used in solution periodically into the arteries. Direct opening of the aneurysm was performed. The old clots, which looked like mud, were removed. The aorta was transected proximally and distally. A tube Dacron® prosthesis was inserted. Mersilene 000 was used in continuous fashion for the anastomosis. Mannitol®, 10 per cent, was infused slowly and intravenously during the half hour of cross clamping of the aorta. Urinary output, measured during surgery, was normal. After the graft insertion, the circulation in the extremities was satisfactory. Bilateral dorsalis pedis arteries were palpable.

Postoperatively, she was given intravenous infusion for a few days. Nasogastric suction was terminated after 24 hours. However, she was not given anything by mouth for five days.

Prior to the turn of the century, aneurysm of the abdominal aorta was a medical curiosity. In 1905, Osler² reported 16 cases of aneurysm. Later Kampmaier² added to the literature description of thoracic and abdominal aortic aneurysm. Present treatment follows the technic described by Dubost.¹ He successfully resected the aneurysm and replaced it with a homograft. Recently a modification of the procedure has been used. This is an opening

of the aneurysm after cross clamping and replacement with a Dacron® graft and encasement of the graft by the walls of the aneurysm. Ninety per cent of the patients were male.¹ The female patients are usually older. Arteriosclerosis is the usual etiologic factor.

Generally, the diagnosis is made on routine clinical examination. Pain occurs if expansion, a retroperitoneal leak, or rupturing occurs. Constant, "boring," mid-abdominal, pelvic, or lumbar pain should suggest an aneurysm. A frank rupture results in rapid exsanguination, hemorrhagic shock, and death. Rupture rarely occurs into the gastrointestinal tract, duodenum, or inferior vena cava. When the patient is meticulously examined, a pulsatile mass is usually palpable in the region of the umbilicus. In that area, tenderness and rigidity are often present. X-ray of the abdomen may reveal haziness of the psoas shadows and a calcified wall of the aneurysm. Intravenous pyelogram reveals the anatomic location of the ureters if they have been displaced by the aneurysm.

The treatment is surgical removal and replacement with a graft prosthesis. If the bifurcation is not involved, it is imperative that a tube Dacron® graft be installed. If there is occlusive disease of the iliac arteries, the arteries are bypassed with the limbs of the bifurcated Dacron® graft. The surgeon has to

be able to rely on immediate expeditious surgery, expert anesthesia, adequate blood replacement, and care of renal function. This may require Mannitol® intravenous infusion. Cross clamping of the aorta for one-half hour was perhaps the major factor in achieving success and survival. Operative mortality is about ten per cent. In emergency resections, postoperative mortality ranges 34 to 80 per cent.¹ The five-year survival rate in all reported cases has been estimated¹ as 65 per cent. Complications, such as hemorrhage, infection, renal failure, homologous serum, jaundice, and pulmonary embolism have been reported. Hypertension and cardiac disease have significantly influenced the survival rate.

Summary

In what is probably the oldest reported patient in literature, with abdominal aortic aneurysm, a 96 year-old woman developed symptoms when the aneurysm expanded. The aneurysm was successfully resected in an emergency procedure. Since bifurcation was not involved, a tubular Dacron® graft was inserted.

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California Grants Immunity To Resuscitation Teams

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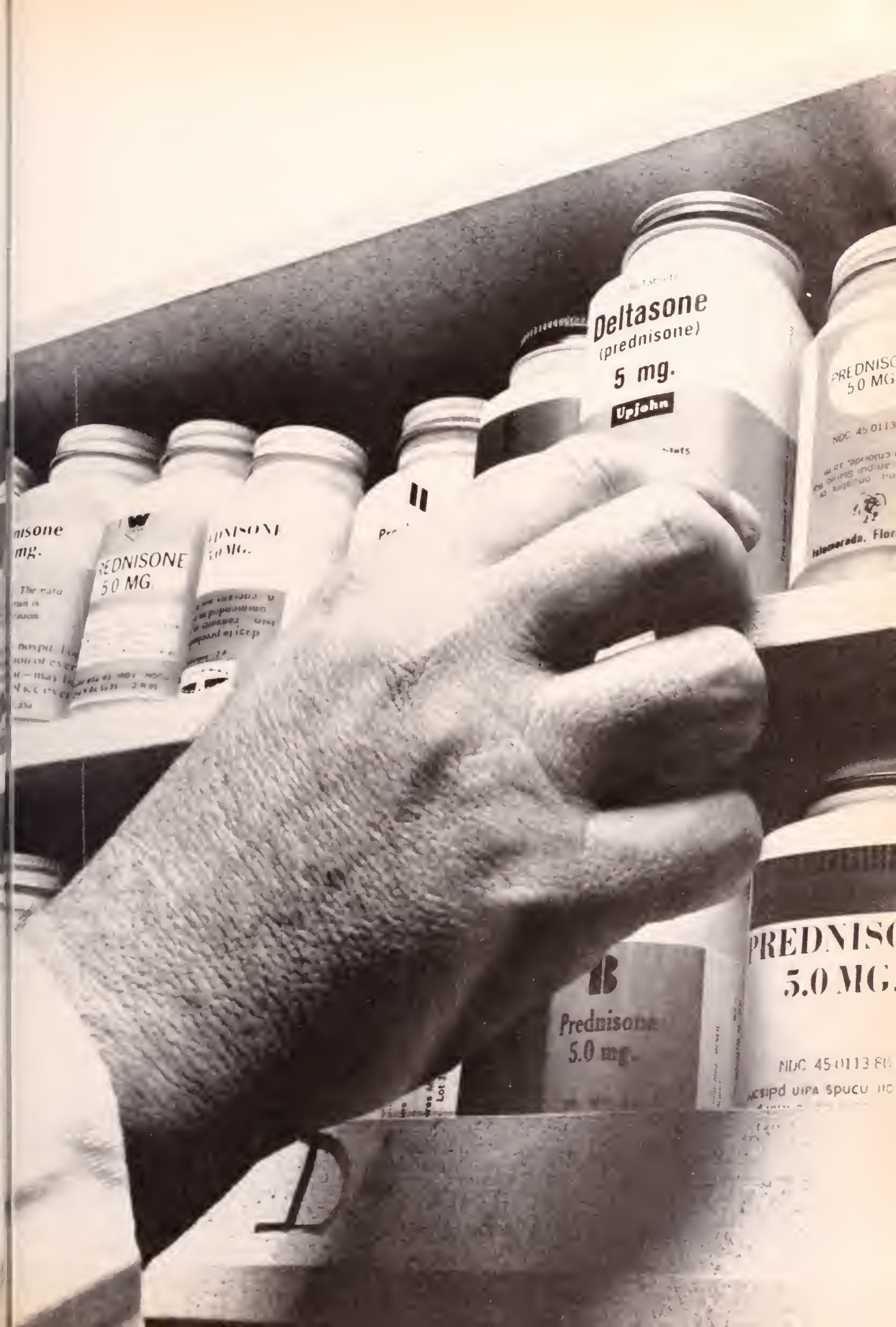
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Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccination, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance

doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9- α -fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoid during pregnancy, since spontaneous remission of some disease such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis an ulcer regimen and antacid are highly recommended. Take X-ray in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fracture; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

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The Practicing Physician In The Rehabilitation Of The Stroke Patient*

Dorothea D. Glass, M.D./Philadelphia

The physician treating the patient who has sustained a catastrophic stroke with resulting hemiplegia and/or aphasia and perceptual loss must assume responsibility for the initiation and direction of an orderly and appropriate program which will enable the patient to progress from dependency to the optimum function possible. Time is critical. The doctor must take advantage of the period of rapid recovery of the neurologic substrate once the stroke has been completed, the vascular status stabilized, and healing begins.

Many hemiplegics who survive the acute insult will have simple enough and minimal enough disability to be handled by the practitioner who has been interested enough adequately to expose himself to and train himself in rehabilitation concepts; and by a nursing staff trained in basic rehabilitation techniques and philosophy.¹ According to a survey in California some years ago (where it is the general practitioner who is the primary source of care for stroke patients), at the time of discharge from the acute hospital, more than half (55 per cent) of these stroke victims were incapable of caring for themselves; 30 per cent were discharged to a nursing home; 2 per cent were non-ambulatory; and 23 per cent had indwelling catheters.² If figures like these are to improve, the primary physician attending the stroke patient must become more sophisticated about rehabilitation. The retraining in self-care and mobility, the knowl-

edge necessary to prevent the complications of deformity and disuse must become part of his armamentarium so that he can initiate a program of maintenance and prevention as soon as the life-threatening situation has been controlled. He must do this even while the patient remains unconscious or on prolonged rigid bed rest (as in cerebral hemorrhage). He must learn to recognize, early, and refer the complex case if his time, interest, and facilities are not adequate to handle it.³

Positioning—For most patients, positioning is simply a matter of physician interest and persistence, plus good nursing care. The patient should be placed on a flat, firm mattress with a small pillow under his head, unless he requires a semi-reclining position because of cardiac complications. Pillows should not be placed under knees and thighs for comfort because they will lead to contractures. Extremities should be placed in a functional position and care taken to prevent lying in one position causing tissue breakdown over pressure points such as the heels, knees, sacrum, and tuberosities. Footboard and footcradle must be used to position the feet at a right angle to the legs. The heels in the supine position and the toes in the prone position should be placed in free space between the end of the mattress and the footboard to prevent decubiti and shortening of the Achilles tendon. Pillows and sandbags may

*Read before the Section on Medicine, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 18, 1970.

be used so as to prevent prolonged external rotation of the lower extremities. The involved upper extremity should be kept in abduction and external rotation with the elbow alternately flexed and extended, the wrist dorsiflexed with fingers extended.⁴

Splints commercially obtained or individually formed may be used judiciously and intermittently to maintain extension of the wrist, fingers, and knee, and dorsiflexion of the foot. The patient who is completely or partly comatose, or who is not yet able to move himself, must be turned every two hours to prevent decubiti, or be placed on a water mattress or turning frame. An ordered routine of passive range of motion exercises should be done twice daily for the involved extremities in both the unconscious and conscious patient, and the patient should, if possible, lie prone for a given period of time to prevent hip flexion contracture.

Exercise—Active movement in bed should be encouraged. Some provision enabling the patient to move himself around in bed such as an overhead trapeze or a side rail must be furnished. At home a sheet may be tied to the end of the bed and knotted for the patient to pull himself up. He must be trained to turn himself. Once spasticity has replaced flaccidity, it helps to apply heat in the form of hot, wet packs to tight joints prior to the regime of passive range of motion exercises.

Careful evaluation of the status of joints, muscles, balance, and sensation perception must be part of the daily examination so that applicable training methods can be instituted or discarded at the appropriate time.

As soon as medically feasible, the patient should be placed in a correct wheelchair and reintroduced to the world outside his bed. He will not be helped by prolonged seclusion in a darkened, quiet room with a minimum of stimulation. For the patient who has just sustained a major shock to his perceptive as well as his motor apparatus, this will worsen the withdrawal and perceptual deprivation that often ensues. As soon as possible, these

patients should be placed in a situation where they will be exposed to stimulation of all the senses and perceptions that they have remaining, including exposure to other patients, staff, family, television, other parts of the hospital or home. If their state is complicated by serious sensory loss, such as aphasia, hemianopsia, hypesthesia, or agnosia, this stimulation becomes more critical.

Range of motion exercises should include full flexion and extension and abduction for the shoulder; flexion and extension of the elbow; pronation and supination of the forearm; and flexion with ulnar and radial deviation of the wrist; finger extension, flexion, and abduction to maintain the web spaces; flexion, extension, abduction, and internal and external rotation of the hip; flexion and extension of the knee; dorsiflexion, eversion, and inversion of the ankle. These movements should be done slowly and fully. Rapid movements increase spasticity.¹ A routine should be taught the patient as soon as possible and also an interested member of the family so that these exercises may be continued at home if necessary.

If the stroke has been uncomplicated by coma, hemorrhage, or myocardial infarct, the mildly involved patient may be out of bed within a day or two. Complications requiring longer periods of bed rest need an established routine of bed exercises to maintain range of motion on the paralyzed side, strength in the uninvolved side, and prevent the numerous complications of bed rest including thrombophlebitis. This is a commoner complication than was previously suspected, occurring often without clinical diagnosis in over one-third of hemiplegics recently studied in a rehabilitation center.⁵ Many of these patients were transferred from the referring institution with unsuspected acute thrombophlebitis.

Once active motion starts to return, the involved muscles must be actively exercised to prevent atrophy, regain strength, and return perceptive awareness. These may be assisted manually or with devices and progressed to resistance in accord with careful periodic

evaluation. Again a routine should be taught the patient and family member.

Complications—Other problems requiring attention include the development of pain in the involved side which may be thalamic or pseudothalamic, or may be due to subluxation of the involved shoulder with stretching of the ligaments and capsule. This is often relieved by use of an appropriate sling, heat, exercise, and mild analgesic medication.

Dentures often become ill-fitting due to relaxation of the involved oral musculature. A patient using dentures should have a dental re-evaluation for revision so that there is an adequate fit. Failure to do this can cause difficulties in swallowing and eating. If there has been previous involvement of the opposite side, a pseudobulbar palsy may be evidenced with swallowing difficulties and inappropriate laughing and crying, often very disturbing to the patient and his family, unless it is explained to them and training is undertaken to correct it.

Daily Living and Wheelchair Training—At the same time as an active exercise program is started, a program for achieving independence in self-care, or activities of daily living, should begin. Appropriate devices to achieve independence in grooming, toileting, eating, and mobility are often necessary and must be tailored individually to the patient. Methods of dressing, grooming, and transfer must be taught at first with assistance and then with supervision. Since many of these patients have suffered sufficient brain damage to produce symptoms of organicity (such as short attention span, inability to concentrate, poor memory and carryover, and concreteness), these technics must be carried out with scrupulous consistency and in a setting that is meaningful to the patient. Periodic evaluations indicate the need for concentration on a particular skill or set of skills necessary to perform these functions. Goals must be set which are understood by the patient and easily enough achieved to permit him to enjoy the satisfaction of success. These patients, once consciousness and cognition have

returned, become aware of the catastrophic loss they have suffered and are usually depressed and often inert and negativistic. They need success as a therapy and their regimen *must* include success to give them the hope to go on.

There are three disabilities which, in a majority of cases, preclude a patient's returning home: the need to be lifted, incontinence, and the need for constant supervision. Daily living training is directed at correcting these. Various methods and devices may be used to assist a patient in independent transfer, including a trapeze bar and side rail, which can also be used for bed exercises. If the need for lifting assistance continues (usually due to a persistent and severe perceptual loss, or loss of balance), then a lifting device, such as a Hoyer lift, is used which requires no strength in the operator, and the patient and family members are taught to use it. It can also be adapted for use in a tub and an automobile. Eating in a community dining-room with other patients is also useful. The communication with others is good stimulation and feeding skills are learned with supervision and special devices. Wheelchairs must be individually prescribed and the patient taught to control direction, using reciprocal movements of the uninvolved upper and lower extremities. These should have a large rear wheel and an 8 inch caster, and should include detachable sides, padded arms, a 4 inch cushion, detachable elevating swing away leg rests, brakes with a brake extension lever and an adequate foot rest. Transport type wheelchairs are inadequate for a patient who has to learn to live from one. Chairs with the large wheel in front increase energy costs and cardiac rate and are too difficult to control for the patient who has to live entirely in one, even temporarily.⁶

Ambulation—At the same time, ambulation training should be started. Patients severely handicapped in ambulation because of major motor or perceptual deficits are probably best referred to a suitable center for training. Patients who have been subjected to prolonged bed rest require a period of recondi-

tioning on the tilt table with gradually increasing verticalization, monitored by pulse rate and blood pressure readings, to recondition the vascular reflexes and prevent orthostatic hypotension. This is also useful for the patient who may have sustained a simultaneous hip fracture to provide gradually increasing weightbearing. Patients are progressed from resting and balancing in the parallel bars to ambulation with a walker, if possible, and then a cane, starting with a wide-based quad cane and progressing as rapidly as possible with careful training, assistance, and supervision. If there is significant proprioceptive loss, dissociation, disturbance of verticality, or hemianopsia, other sensory cues, especially visual, must be emphasized to compensate.⁷ Therefore, this training is done in front of mirrors and with constant verbal reinforcement. Dorsiflexion assistance *via* individually prescribed and fitted braces may be needed, and if so, will cut down on the energy used in walking.^{8, 9, 10} The patient must also be trained to manipulate stairs, curbs, and slanted surfaces since architectural barriers are everywhere. A lack of these skills dooms the patient to isolation and segregation from the world. If independently ambulatory, he should be timed crossing the street so that he can pace himself within the time duration of the usual traffic light. He should also be trained to get in and out of an automobile, and if the disability is mild enough, he may be trained to drive again.

Bowel and Bladder Training—Bowel and bladder training must be among the first regimens instituted. Bowel training is mostly dependent on a consistent, persistent routine of adequate fluid intake, use of daily stool softener, use of a suppository at mealtime to stimulate toileting following a meal to take advantage of the gastrocolic reflex. The patient must also be given enough time to sit on the commode in comfort and with security. If stronger measures are needed, prune juice, Dulcolax® at bed time and a Dulcolax® suppository are added. The time selected should be appropriate for the patient's way of life. A man who is going to work in the morning may not have the time for an adequate rou-

tine after breakfast and, therefore, should be trained to evacuate after the evening meal. Most patients will not have or need a daily bowel movement, and they should be reassured that every second or third day may be normal and healthful for them.

Most hemiplegics should not require an indwelling catheter unless they are so severely damaged mentally that control is impossible. There are very few so badly damaged. After thorough genito-urinary evaluation (to rule out organic causes of incontinence) the catheter should be removed and a program of timed voiding instituted (every two-to-three hours usually). Residual urine must be checked. Outlet obstruction may require transurethral resection in males and urethral dilation in females. Any infection as evidenced by a culture should be treated with the appropriate antibiotic.

Perception and Sensation—Impairment of sensation and perception diminishes further the hemiplegic patient's ability to cope with, or react to, changes in the environment. Psychological testing will define what perceptual impairment exists. Asymmetric loss of sensation has been shown to be severely disabling in the performance of motor acts. The left hemiplegic is especially likely to have perception impairment as the right hemiplegic is to suffer from aphasia. Hemianopsia on the involved side requires retraining to compensate. Hearing loss, which may have previously been present but compensated for, now becomes more significant and should be tested for and corrected if possible with a hearing aid and training. Asterognosis may seriously interfere with the ability to handle utensils, manipulate objects, and ambulate. The patient must learn to compensate for this visually. Some patients completely dissociate an involved extremity, as though they had lost the endgram in the brain, and experience great difficulty in trying to control a body part of which they are unaware. Body-image distortion is equally damaging to skilled performance. Stimulative relearning and training modalities and electrical stimulation may be used to help correct this.

Speech—Aphasia, when present, usually involves both receptive and expressive components. This requires the services of a specially-trained therapist, if severe. Some minor word-finding difficulty can be compensated for by circumlocution and other compensatory mechanisms without significant functional loss. Often receptive difficulty is not obvious because a patient has learned to approximate social response well enough to cover up. Therefore, skilled testing is advisable with training provided as needed. If severe aphasia is present, it is important to work out the prognosis for functional speech in order to advise the family not to pursue this goal if it is unlikely to be achieved. Loss of speech is one of the greatest frustrations the hemiplegic patient must bear. Much work needs to be done in this area to clarify the mechanisms and improve recovery. Dysarthria usually improves and may be hastened with a program for exercising the speech musculature, unless there is bilateral involvement.

Psychologic Implication—The normal person faced with the disaster of full-blown hemiplegia is sure to be depressed once he has recovered sufficient awareness. This is an expected reactive depression, a grieving time, and he must be helped to manage it and work it through *via* an active and supportive psychological treatment. Crucial factors are his premorbid personality and the support his family is able to give. Many of these patients suffer from inertia and perseveration. Those responsible for his retraining must be aware of this and work consciously to correct it. New methods of training, such as operant conditioning, appear worthy of trial if conditions can be set up to utilize them, but this requires trained personnel and constant direction.

Family and Home—From the first, the family should be made a part of the patient's training. Discharge planning should be started as soon as the eventual functional status is perceptible. An active Social Service Department is practically a necessity. Many patients are extremely fearful concerning the attitudes of their family members, especially their mates,

and of rejection and disposition outside the home. The enforced dependency, even though it may be brief, can severely upset the patient's self-concept of his role in the family.

Sometimes dependency results in secondary gains of increased attention, and coddling, with regression to an immature relationship in the family constellation. Dependency may also represent a chance to escape from a distasteful work situation or an unwanted position of responsibility in the family.

Alienation from the family constellation may be a problem with long-term hospitalization. At first, the loss of the patient from the family group leaves a large hole; then, as the daily life of the family goes on without the patient the other members learn to adapt and compensate—the hole closes up, and may leave no room for the return of the patient, especially if he still has severe enough involvement to require major revision of the usual routine of family life. Weekend leaves from the hospital to spend time at home while learning what adjustments, both physical and psychological, may be needed, and day hospital and home care programs are useful to prevent this problem.

Problems of sexual activity must be discussed with the patient and spouse who are still sexually active. Rarely will the patient initiate this, but it is a major source of concern to both and should be worked out under the careful control of the physician and in keeping with the patient's general medical status.

Follow-up of the patient's functional achievements, as well as his medical findings, must be part of any rehabilitation program. Early problems, such as impending limitation of motion, brace problems, and loss of functional control can be thus identified and taken care of before they develop into major problems sometimes requiring rehospitalization. The transition period between hospital and home is a critical one and one that is often not well managed. It must be successful in order to return the patient to his optimum functioning as a human being rather than continuing as a patient.

Vocational Rehabilitation—Since many of the patients suffering a stroke are in the retirement, or near retirement, age group vocational rehabilitation is often overlooked. But for the younger age hemiplegic (the child, or young wage earner, or the housewife, suffering from the rupture of an aneurysm) the need to make a vocational readjustment is as critical as any. A fair number of mildly involved patients do not need readjustment or make their own. The others should have help in identifying their residual skills, whether or not these can be adapted to their previous work situation, or if retraining is needed for a new situation. Transportation to and from work is often an impossible barrier and, therefore, relearning to drive, may be critical.

Evaluation and retraining may require special facilities. The physician may assist the patient by referral to those agencies in the community. However, this is often an area of limited potential, and much more investigative work needs to be done.

Summary

It is the responsibility and duty of the medical doctor managing a hemiplegic patient to bring all the knowledge and resources of the hospital and community to his patient, to help him develop the most of whatever residual potential there is once the medical crisis has passed. For the less involved pa-

tient, this can often be best managed in the home or primary institution by a well-informed and concerned physician. For the maximally involved patient, referral to a center which is competent to handle major disability is often advisable. Failing to accomplish this will abandon the patient to the terrible big "D's" of Disability, Deprivation, Dependency, and too often, Discard.

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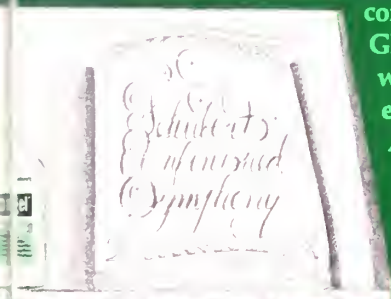
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Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

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Perhaps it is time to establish and enforce blood donor screening procedures.

Drug Detection In Urines Of Commercial Blood Bank Donors

Richard J. Coumbis, Ph.D., et al.*/
Newark

Annual usage of blood now amounts to approximately six million units. Commercial blood banks vary widely in their donor selection criteria and it is a considered opinion that many donors should be rejected on medical grounds. Of principal concern is the heroin addict, with the heightened incidence of infectious hepatitis in such a population. Blood banks use a history, an abbreviated physical examination, and blood serology as the primary screening procedures. They are presently in the process of introducing a test for the presence of the Australian antigen. This preliminary study reports data obtained from the analysis of urines collected from 50 donors who gave blood at a commercial blood bank. The discovery of four probable heroin addicts attests to the importance of additional screening procedures. Whether such a urine screening program should be used generally or in a more restricted manner applicable to a local donor population is a moot point.

We collected 50 urine samples obtained at a commercial blood bank from random blood donors (ages 18 to 24). These were analyzed for the presence of drugs. The specimens were fresh, collected without a preservative, and processed the same day.

Direct extraction at a pH 2 with ether and a pH 11 with chloroform were applied to each sample. Each urine in addition was acid hydrolyzed and extracted with chloroform iso-

propanol at a pH 8.5.

Acid fractions were tested with cobalt acetate lithium hydroxide reagents for barbiturate screening, and with a ferric chloride reagent for the screening of salicylates. Thin-layer chromatography and ultraviolet spectrophotometry were employed for positive identification. Basic fractions were spotted on silica gel plates, and examined for fluorescence and the presence of other unknown compounds. Ultraviolet spectroscopy and chemical crystalloscopy were utilized for final and definitive identification. Results are displayed in the following table:

DRUGS IDENTIFIED	NUMBER	RATIO
Barbiturates	1	
Morphine	2	
Nicotine	2	
Quinine	3	
Salicylates	7	
Negative	35	70%
Positive	15	30%

A critical evaluation of the positive urinary findings in these cases must be tempered by the absence of quantitation and the simple non-contributory history on each donor, indicating that he was not ill and not on any form of medication. There are individuals who would probably not consider salicylates as medication, and indeed the same might also apply to barbiturates. Whether such medication relates to a low grade illness cannot

*Co-authors are Edwin Albano, M.D., State Medical Examiner, and Michael Lyons, M.D., Department of Pathology, New Jersey College of Medicine and Dentistry. Dr. Coumbis is the forensic scientist with the State Medical Examiner's Office.

be determined. Nicotine undoubtedly correlates with smoking and is considered to have no further meaning.

Morphine absolutely and quinine relatively are significant findings. Morphine, unless prescribed, is an indication of narcotic (heroin) abuse. A simple heroin injection, with a positive urine morphine recovery, would more than likely indicate addiction. When quinine is found in association with morphine, it is virtually pathognomonic of a drug abuse, inasmuch as quinine is still the most common adulterant in the heroin sample. Quinine by itself may simply indicate that the person has been drinking beverages containing quinine compounds, such as tonic water. Since quinine urine secretion will persist for approximately three days beyond the last point of urine morphine recovery, one

must recognize the distinct possibility that the findings may represent a drug abuser with an intermittent habit.

The primary purpose of our report is to demonstrate the value of blood donor urine screening procedures to uncover drug abusers, with particular reference to the heroin addict and the problem of transfusion hepatitis. The data demonstrating positive drug urinalysis (30 per cent) further raises the question of the incidence and amount of various drugs in a unit of donor blood. The significance and effects of such drugs would depend on the level (s), the amount of blood given the patient, and the patient's primary disease. It is not intended to over-react to these preliminary data, but to simply indicate an area of practical importance, which merits further attention and investigation.

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2. *Notification*—The patient's whereabouts and physical condition must be made known immediately to the nearest Army Surgeon's Office when emergency civilian medical treatment is required. The telephone call may be made by the patient or a member of the hospital staff. Keep a record of the full identification of the person accepting the call for

the Army. The cost incurred in notifying the military authority is a legitimate charge to the Army and should be included with the medical bill. (Personal calls made by or for the patient may not be included.)

3. *Billing*—The bill should be submitted in quadruplicate, showing *all* the information acquired in step I. With the dates of service, the bill should list the individual charges for each type of service (ambulance, diagnostic, medical, surgical, or other) together with a signed certificate embodying the following statement: "I certify that the services were necessary in the treatment of the above named person; that the services were as stated; and the charges are not in excess of those customarily made in this vicinity."

4. *Mailing*—The bill should be mailed to the appropriate Army Surgeon for the area in which the service was rendered. To get the address call (301) 677-2466 or 3616.

When to take the chest-injured patient to the operating room, and, just as important, when not to, is reviewed in this compact monograph.

Surgical Indications In Chest Trauma*

James W. Mackenzie, M.D.
New Brunswick

Among males from 15 to 30 years of age, trauma is the most common cause of death. Automobile injuries are the most frequent type of injury, and thoracic wounds are second only to cranial wounds as the cause of death from trauma. In general, even patients suffering severe thoracic trauma are best treated *without* thoracotomy. Proper attention to the cardiopulmonary status, thoracentesis, insertion of large intercostal tubes, and, occasionally, tracheostomy with controlled ventilation usually suffice. These conservative tenets are the direct result of experience of military surgeons in World War II and have been supported by the experience in the Korean War² as well as in the conflict in Vietnam.⁵ With fuller understanding of pulmonary physiology, wider availability of well-trained anesthesiologists and surgeons, and supported by improving laboratory facilities, cautious expansion of the indications for thoracotomy is being evaluated.^{1, 4, 14}

The currently well accepted indications for thoracotomy are listed in Table I. Also note Table II which lists five conditions, the treatment of which is undergoing re-evaluation.

Large Clotted Hemothorax

Most patients with significant intrathoracic hemorrhage after trauma⁵ do not require thoracotomy.¹ Perhaps 20 per cent of these will require thoracotomy for control of bleeding. The hemothorax of patients with significant intrathoracic bleeding (who do not re-

quire thoracotomy for control of hemorrhage) is usually evacuated adequately by thoracentesis or insertion of large intercostal tubes. Occasionally, however, the blood clots early and rapidly. Based upon the military experience in World War II, most writers⁶ advocate waiting some three to six weeks following injury before the clot is evacuated.¹² Civilian experience, however, suggests that there is nothing magic about the period of three to six weeks after wounding. If the patient's general condition is good this blood can be safely evacuated at thoracotomy with saving of time in the hospital. One advantage of waiting the prescribed three to six weeks is that the operation may not be indicated as the pleural surfaces have the ability to absorb significant amounts of blood. Obviously, therefore, only large amounts of blood remaining within the

TABLE I
Thoracic Trauma

Currently Accepted Indications For Thoracotomy

1. Thoracoabdominal wound.
2. Traumatic thoracotomy.
3. Continued hemorrhage.
4. Suspected tracheobronchial laceration.
5. Suspected esophageal laceration.
6. Large intrathoracic foreign body.

TABLE II
Thoracic Trauma

Conditions Undergoing Re-evaluation

1. Large dotted hemothorax.
2. Cardiac tamponade.
3. Mediastinal widening.
4. Traumatic aneurysm.
5. Instability of sternum.

*Read before the joint session of the Section on Chest Diseases and the Section on Surgery, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 18, 1970. Dr. Mackenzie is Professor and Chairman, Department of Surgery, Rutgers Medical School.

pleural cavity should be evacuated by thoracotomy.

Cardiac Tamponade

Most physicians are familiar with the effects of acute cardiac tamponade. There is a small quiet heart with moderate elevation of venous pressure and depression of arterial pressure. Until recently it was taught¹ that the proper initial treatment of cardiac tamponade was pericardiocentesis. Only with recurrence of symptoms was cardiorrhaphy thought indicated.^{3, 9} Such an approach requires meticulous observation of the patient following the pericardiocentesis, and facilities and personnel available on very short notice for control of recurrent intrapericardial bleeding. The trend toward immediate thoracotomy in these cases is probably a better policy for most hospitals.^{4, 10, 14}

Mediastinal Widening

Only within the past twelve years has there been general recognition of the significance of mediastinal widening as detected by chest x-ray of patients who have suffered recent trauma. Mediastinal widening may be caused by transection of a major intrathoracic vessel, usually the aorta. Surprisingly, 15 per cent of the people who suffer this injury may survive long enough to reach the hospital.¹¹ It is often difficult to be sure the apparent mediastinal widening is real because of the known distortion of the mediastinum associated with portable roentgenograms. Displacement of the trachea to the right and elevation of the left main bronchus are confirmatory signs that one is dealing with transection of the descending aorta. Fortunately, most patients with "mediastinal widening" following trauma do *not* have a ruptured major vessel. Nevertheless, those whose mediastinal widening is due to transection of the aorta are in a precarious state. The possibility of sudden death within a few days is real. Confirmation of the diagnosis is necessary in all patients in whom this lesion is suspected. After confirmation by aortography, repair of the lesion by direct anastomosis or, more commonly, by insertion

of a short prosthesis is indicated as an urgent procedure. Support for the vascular supply to the spinal cord and to the abdominal viscera is necessary during the procedure as is decompression of the heart. Several satisfactory methods are available to provide this protection. Femoral artery to femoral vein bypass (using an oxygenator in the circuit), left atrium to femoral artery bypass, or the use of a simple shunt from the transverse ascending aorta to the distal aorta all give satisfactory results.

Traumatic Aneurysm

Some patients may survive acute transection of the aorta without repair.⁸ They then may appear with aneurysm of the aorta some years later.¹³ These patients usually are asymptomatic but may have symptoms from local pressure⁷ or from the development of narrowing at the site of the false aneurysm.¹¹ Most surgeons favor operation after discovery of these asymptomatic aneurysms because they fear rupture of the aneurysm. In this regard it should be noted that rupture has been reported some eighteen years after injury.⁸ There is little question that patients with symptoms from these aneurysms or those in whom it has been demonstrated that the aneurysm is enlarging require operation. The treatment of patients of middle age or older who have had a known traumatic aneurysm stable for many years is difficult to determine. The true life history of these aneurysms is unknown. Our own preference would be toward conservatism in these asymptomatic patients whose aneurysm is known to have been present and stable for some years.

Instability of Sternum

Treatment of patients with crushing injury of the chest wall is usually conservative. Those patients with simple uncomplicated fractures of the ribs and sternum may be treated with analgesics and, occasionally, intercostal nerve block. Some patients may have massive paradoxical motion and require tracheostomy with positive pressure ventilation for stabilization of the chest wall and survival. Direct open operation for stabilization of ribs has not been

satisfactory. Certain patients, however, may have simple fracture of the sternum with significant overriding of the fragments. This fracture may contribute significantly to the patient's discomfort as well as to inefficient respiration. Careful reduction of the fracture with fixation by wire suture in place can be of real help. One must be careful when performing this procedure that *absolute immobility* is obtained; otherwise there will be breakage of the wire.

Summary

1. Most patients with thoracic trauma are best treated by conservative means.
2. The classical indications for thoracotomy derived from the experience of military campaigns are still applicable to civilian practice.
3. Cautious expansion of the indications for thoracotomy is indicated.

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Pancreatitis is an exceedingly rare complication of salmonella enteritis. Here is one such case.

Pancreatitis With Salmonella Gastroenteritis*

Newton D. Scherl, M.D./Fort Lee and
David L. H. Patterson, M.B./Englewood

Salmonella infections have been observed with increased frequency during the past decade. Although numerous other clinical patterns have been described, gastroenteritis, the most common, is present in about 70 per cent of cases.¹

Certain unusual manifestations of the disease, including osteomyelitis, aneurysms, meningitis, and appendicitis have been reported. This disease has also been seen as a complication of other diseases, including cirrhosis, malaria, and sickle cell anemia.²

Although gallbladder disease is a frequent sequel of salmonella infection, the literature does not record pancreatitis as a complication. The following case report is believed to represent pancreatic involvement in a case of salmonella gastroenteritis.

Report of a Case

A 12 year old boy was admitted on August 14, 1967, with a 48 hour history of fever and vomiting. The illness began suddenly 36 hours after a family picnic. At the time of admission, he appeared toxic and dehydrated. His temperature was 102. The abdomen was soft, but diffusely tender. Shortly after admission, profuse diarrhea was noted. The abdomen was slightly distended and bowel sounds were diminished. A transient erythematous rash was observed. Dilated loops of small bowel, with air-fluid levels, were seen on a plain film of the abdomen. Findings on sigmoidoscopic examination were unremarkable. His temperature ranged between 102 and 103 from August 14, 1967 through August 19. Treatment with chloramphenicol was begun on August 18, 1967 and continued for one week. On August 20, the temperature dropped to 100 and remained at 99 to 100 through August 26, after which the patient was afebrile for the remainder of his hospitalization.

The stool cultures failed to grow out a salmonella or any other enteric pathogen. The agglutination studies, however, after being negative on August 18, 1967, showed a rise in titre of paratyphi C to 1 to 640 on August 25, 1967. This titre remained elevated on September 6 and September 13, before returning to negative on September 25, 1967. In addition, the titre to salmonella B, C, and E rose to 1 to 40 on August 18, and to 1 to 640 on August 25, 1967. These titres remained elevated on September 6 and September 13, before decreasing to 1 to 80 on September 25, 1967. All other titres remained negative.

Early in the illness, a leukocytosis with a marked shift to the left (40 per cent) was noted. The serum bilirubin, alkaline phosphatase, and SGOT were all within normal limits.

Within a week after admission the nausea, vomiting and diarrhea had subsided. The abdomen was soft and non-tender. The patient was given oral liquids but was unable to retain them. Three hours after ingestion, he would vomit a large amount of green, watery liquid. After three days of persistent vomiting, an upper gastrointestinal x-ray showed a marked delay in gastric emptying without evidence of obstruction. The stomach appeared dilated. A very small amount of barium passed into the small bowel. Nasogastric suction was begun and on August 25, 1967 serum amylase was reported as 250 units (normal 60 to 160 units) with a serum lipase of 4.0 units (normal less than 1 unit). The urinary amylase was 245 units (normal 38 to 207 units per hour). The patient was treated with continuous nasogastric suction and intravenous fluids. Over the next two weeks, repeated amylase and lipase determinations showed significant elevations with a serum amylase range of 250 to 550 units and the serum lipase rising to a level of 9.5 units. The patient remained free of pain but continued to vomit whenever the nasogastric tube was clamped. During the fifth week of hospitalization (and the third week of continuous nasogastric suction) the patient retained his first oral feedings. He had lost 20 pounds since admission. Serum enzymes were still elevated at the time of discharge with a lipase of 3.5 units. The urinary amylase was also elevated to a level of 455 units. It was not until two weeks after discharge that the enzyme studies were normal.

Gallbladder x-rays obtained shortly after discharge were completely normal. The patient made a complete recovery after discharge from the hospital. He has no evidence of pancreatic calcification on x-ray examination.

*From the Medical Service of Englewood Hospital, Englewood, New Jersey. Reprint requests should be directed to Dr. Scherl at 1319 Anderson Avenue, Fort Lee, New Jersey 07024

tion of the abdomen. Numerous stool cultures were negative.

Comment

Despite the absence of stool culture confirmation, the clinical course and elevated salmonella titres are consistent with a clinical diagnosis of salmonella infection. This infection was associated with pancreatic involvement, producing a painless pancreatitis, manifested by severe gastric atony and dilatation. The clinical picture simulated a high intestinal obstruction and this diagnosis was considered, with the possibility of surgical intervention, until the pancreatic enzyme studies were obtained.

Since bile is an ideal medium for the growth of salmonella organisms, it would seem possible for the pancreas to become involved secondarily by regurgitation of infected bile into the pancreatic duct at some stage of the illness. Indeed, it is surprising that this does not occur more frequently. Direct hematologic spread could also infect the pancreas. This would be most likely to occur during the bacteremia often associated with the acute stage of the disease. Although the pancreatitis may not have been due to a bacterial infection, but rather a non-specific pancreatitis

following severe abdominal insult, we feel the temporal relationship of the events suggests a salmonella infection of the pancreas.

Summary

A 12 year old boy was admitted to the hospital with an acute febrile illness and severe diarrhea. The patient developed very high titres to paratyphi group C and salmonella groups B, C, and E. After treatment with intravenous chloramphenicol the diarrhea ceased and temperature returned to normal. The patient however developed severe gastric dilatation and atony associated with inability to retain oral feedings. Serum and urinary amylase and serum lipase levels were strikingly elevated and remained abnormal for five weeks. The patient required prolonged treatment with nasogastric suction. Gallbladder disease was not demonstrated. It is our conviction that this represents a case of salmonella pancreatitis complicating an acute salmonella gastroenteritis.

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Hyponatremia does not automatically mean a sodium deficiency, and is not automatically correctible by high sodium intake. It can mean a lot more—or less.

Hyponatremia Of Diverse Etiology

Edwin Kellerman, M.D./Margate

Hyponatremia is a chemical imbalance not infrequently encountered in the management of seriously ill patients. Since natrium means "sodium," you might think that hyponatremia reflects a deficiency of sodium and is correctable by the administration of sodium. In practice, mechanisms other than sodium deficiency are responsible for this condition so that treatment must be individualized depending upon the pathophysiology involved. In this paper, I will describe five separate instances of hyponatremia encountered in the last year and discuss pathophysiology and treatment.

False Hyponatremia

A 60 year old female was admitted to the hospital in diabetic coma. Her blood sugar was 1225 milligrams per cent. Her serum acetone was positive in 50 units. The following electrolyte values were obtained on admission—NA 115, K 5.1, CL 51, CO₂ 16, and pH 7.24. At first glance, it might be concluded that this patient was markedly depleted in sodium. Yet, the corrected serum sodium concentration for the degree of hyperglycemia would indicate that the major deficit was in water and that the serum sodium concentration was falsely depressed due to the marked hyperglycemia. This magnitude of elevation of blood sugar raises the serum osmolality by more than 50 milliosmoles per kilogram. This created a hyperosmolar state requiring large amounts of hypotonic fluids for correction. This patient was given, over the next 72 hours, approximately 10,000 cubic

centimeters of 2½ per cent dextrose in half strength saline. As a result, sodium concentration was raised to 132 meq/L, and, with appropriate doses of insulin, the antecedent very high levels of blood sugar were lowered, reducing the serum osmolality to more normal levels. Had the patient been given hypertonic saline in this instance, a worsening of her condition could have been expected because of further elevation of the hyperosmolality which existed on admission to the hospital.

Hyponatremia Secondary to Hypokalemia

A 57 year old male was admitted to the hospital for a severe pneumonia. There was a past history of hypertension and pulmonary emphysema. His electrolyte pattern was as follows—NA 122, K 2.9, CL 70, CO₂ 36, and pH 7.59. There was marked weakness of all of his extremities. He was lethargic and confused. An aliquot of his urine revealed a sodium concentration of 12 meq/L and potassium 25 meq/L thereby excluding abnormal urinary losses of sodium and potassium as a cause of his hyponatremia and hypokalemia. Because of his past history of hypertension and suspected severe vomiting prior to admission to the hospital, it was decided to administer potassium chloride in the hope that both his serum potassium and sodium would be corrected to normal levels. It must be appreciated that with severe potassium deficiency a degree of hyponatremia is likely to develop in an attempt by the body to maintain intracellular and extracellular osmolality equal. Potassium, being mainly an intra-

cellular electrolyte, when it is significantly depleted from the body, will cause a lowering of the serum sodium concentration as sodium migrates intracellularly. This patient, over a 48 hour period of time, was given 200 meq. of potassium chloride intravenously. He received no sodium therapy. However, at the end of the 48 hour period of therapy his electrolyte values were as follows—NA 131, K 4.1, CL 85, CO₂ 31, and pH 7.46. Of interest here was the fact that despite the reestablishment of a normal serum potassium concentration with a concomitant elevation of serum sodium concentration there remained a slight degree of alkalosis indicative of the potassium deficiency.

Hyponatremia Secondary to Inappropriate Secretion of Anti-Diuretic Hormone

An 80 year old female was admitted to the hospital with a traumatic subarachnoid hemorrhage. On admission her serum electrolytes were as follows—NA 130, K 3.8, CL 90, and CO₂ 31. However, despite daily intravenous fluids containing approximately 4.5 Grams of sodium chloride, in addition to Decadron,[®] it was noted that her serum sodium concentration was falling and that she was becoming progressively more comatose. Three weeks after admission to the hospital her electrolyte pattern was as follows: NA 105, K 5.9, CL 75, and CO₂ 20. A 24 hour urine specimen at that time revealed a sodium content of 4.9 Grams and a potassium content of 1.6 Grams. The serum osmolality was 249 with a urine osmolality of 655. Tentative diagnosis was hyponatremia secondary to the inappropriate secretion of anti-diuretic hormone. This is an interesting and rare syndrome described in various clinical settings including certain neurologic disturbances wherein despite severe hyponatremia and hypo-osmolality of the serum, there is an excessive loss of sodium in the urine wherein the urine is persistently hypertonic to the serum. Further administration of saline in an attempt to correct the hyponatremia in this condition leads only to a worsening of the hyponatremia and the pa-

tient's clinical state. Therapy in this instance is directed toward a restriction of fluid intake which results in a reduction in the production and effect of anti-diuretic hormone, resulting in an elevation of the serum sodium concentration. In this instance, fluids were restricted to a total volume of 600 cubic centimeters a day containing a total of two Grams of sodium. As a result, within the next 24 hours the serum sodium concentration began to rise and at the end of a week it was 130, with a resultant increase in the patient's level of consciousness in that her previous comatose state was corrected to a state in which she was able to respond to verbal stimuli.

Dilutional Hyponatremia

An 81 year old woman was admitted to the hospital for resection of a carcinoma of the right side of the colon. On a previous admission, diagnosis of cirrhosis of the liver had been made and confirmed by liver biopsy. Her electrolyte pattern was as follows: NA 121, K 4.6, CL 84, and CO₂ 30. The first plan was to give her intravenous saline in an attempt to elevate her serum sodium concentration. However, further thought and evaluation led to an alternative approach more in keeping with her patho-physiology. It was noted that she had considerable body edema, thought to be related to her chronic cirrhosis. Her serum albumin level was only 2.1 Grams. In this instance, as in most cases when there is evident body edema (even though there is a degree of hyponatremia) it is important to realize that this hyponatremia is a dilutional effect and that in reality total body sodium is elevated but less so than the more marked elevations of total body water, thereby creating apparent hyponatremia. This type of dilutional hyponatremia, in addition to being common in patients with cirrhosis of the liver who have edema, is also common in patients with chronic congestive heart failure. Administration of saline to these patients only leads to a worsening of their edematous, congested state. In this instance, instead of the administration of saline, it was recommended that fluids be restricted. As a result the serum

sodium concentration became elevated to normal levels.

True Depletional Hyponatremia

A 76 year old female was admitted to the hospital for treatment of pneumonia. She had been using enemas and laxatives on a regular basis, prior to admission to the hospital, to ensure a daily bowel movement. Her condition worsened soon after admission to the hospital with the development of a hypotensive state. Her serum electrolytes were then found to be as follows: NA 103, K 2.3, CL 59, CO₂ 29 and pH 7.49. The patient was obviously severely dehydrated. A central venous pressure catheter was inserted with an initial reading of 4 centimeters. Provisional diagnosis was severe sodium depletion. In the next 18 hours the patient received intravenously 1500 cubic centimeters of normal saline and 90 meq. of potassium chloride. As a result, her hypotension was corrected with the following serum electrolyte concentrations—NA 116, K 5.6, CL 80, and CO₂ 24. It was concluded that her overuse of enemas and laxatives had led to a severe electrolyte and fluid depletion which was responsible for her hypotensive state. In this instance the administration of saline was deemed appropriate and in fact did prove beneficial clinically.

17 South Essex Avenue

Summary

We have described the spectrum of hyponatremia as encountered in hospital practice. While at first glance this chemical imbalance might induce some clinicians immediately to administer saline, this form of therapy is not usually appropriate. It is only by an understanding of the pathophysiology of electrolyte and fluid imbalances that one can intelligently initiate treatment of this disorder. As exemplified in the description of cases in this paper, appropriate therapy could consist of (1) Administration of hypotonic saline, (2) Administration of potassium, (3) Restriction of fluids and (4) Lastly the administration of saline. As in most instances in medicine a meticulous history and physical examination together with relevant laboratory studies will, with an appreciation of the patho-physiology involved, lead to the most appropriate treatment.

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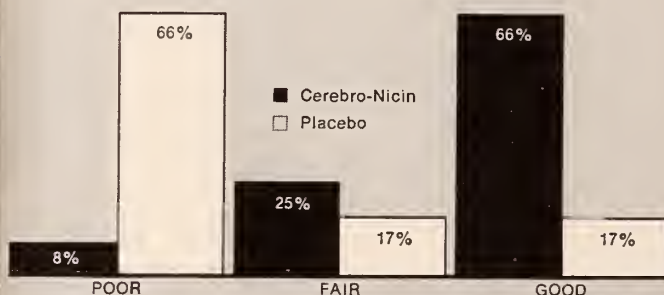
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Even prior to conception, there is an interaction in the gametes between genes, their carrier chromosomes and the environment. This constant interplay determines whether the subsequently fertilized egg will be involved with a hidden previously non-expressed deleterious gene that a parent might carry or with a new genetic mutation; whether the chromosomes will be normal in numbers or in their individual configuration, i.e., translocation chromosome carrier state in one normal appearing parent, and the sex chromosome composition which will influence whether there will be a higher risk for the appearance of certain genetic diseases which are dependent for their expression on whether the child is a male or a female.

Genetically, we are not all created equal. The simplest illustrations of that fact can be found in comparison between Sophia Loren and Twiggy or John Wayne and Truman Capote. The spectrum of genetic variations in individuals has important survival value for the human species.

There is a polygenetic or multifactorial inheritance pattern for many traits. These features are derived by small contributions from many genes. In essence, this means that there is a marked spectrum of normal variability and that there can be no sharp definition between normal and abnormal. Thus, we define the normal standards by the distribution of particular traits in a particular population. This distribution produces a bell shaped curve for each trait with the midportion (50th percentile) wide peak of the bell curve comprised of the largest group of individuals with that trait as quantitated by measurements. The curve falls off at either end with plus or minus two standard deviations from the mean (50th percentile) containing approximately 95 per cent of the population with the characteristic being studied. There is extreme *normal* variation at each end of the curve, e.g., for weight, a 12 year old girl might weigh 125 lbs. or 62 lbs. and still be considered normal.

*Presented in North Brunswick, New Jersey at the Conference on Comprehensive Child Care sponsored by the New Jersey Chapter American Academy of Pediatrics and New Jersey Public Health Association, April 22, 1970. Dr. Kushnick is Professor of Pediatrics at the New Jersey College of Medicine and Dentistry.

Environmental-genetic interreaction for every normal feature (and disease) shows variation as to the ratio contributed by each factor in a specific situation. As an example, a child who is destined genetically to have normal intelligence, height and weight, and who develops measles encephalitis, will subsequently show severe failure to thrive and the genetic potential for his height, weight, and intelligence will never be achieved. In this case, almost all of the effect is due to environmental causation.

Ultimately, one of the problems in dealing with normal variants is to define whether a particular characteristic *is* normal in comparison to the possible extreme variations of the norm. If the characteristic is definitely abnormal, then the problem is to define the extent that this abnormality is due to genetic or to environmental causation, with the realization that both are involved to some degree. As an example, short parents will produce short, slow-growing, slow-maturing but normal children. If the child is truly dwarfed, one must diagnose whether this is genetic on a sporadic or inherited basis or whether it is environmental in origin.

Impingement of the environment on the genes starts prior to conception and continues through intrauterine life and post-natally. The peak influence is in the early infant and childhood years. The latter aspects include such influences as maternal love or neglect of the child; the amount of intellectual stimulation the child receives in the home; the sensitive, but not critical, periods for an infant to learn new skills and mature; and, most important, the nutritonal state of the child. This is a two-directional affair concerned with what the child *seems* to be to the parents and *what the child* actually is genetically as modified by his environment.

Intrauterine Life

Each of us carries 3 to 8 hidden deleterious or lethal genes. These may be expressed with any pregnancy. Of great interest is the possibility that maternal genes alone may influ-

ence the earliest development of the fertilized egg and the maternal harmful genes might not be offset by paternal normal genes at this early stage. The earliest zygote uses cytoplasmic stored maternal messenger materials before the paternal genes are activated in the paternal chromosomes. There is experimental animal proof for this and it does raise the possibility that a single deleterious gene from the mother might be harmful in the earliest stages of embryonic development.¹

Genes are responsible for the control of the formation and differentiation of the fetal organs. Thus, the earlier during the pregnancy that any adverse gene effects are exerted, the more likelihood of increased adverse affects to the fetus.

If the mother has optimal prenatal care and nutrition without the abuse of drugs or smoking there is the best potential for normal genetic expression in the development of the fetus.

Health Care and Evaluation

If a child has a normal growth process with optimal nutrition, certain features of physical growth and development can be expected on a genetic basis.²

Heights are an expression of the average of the parents' heights. Tables have been formulated for a child's height at various ages with this mid-parent height average as the basis. Tall parents will produce tall children and short parents will produce short children. All normal children will, however, have their heights within plus or minus two standard deviations of the 50th percentile in the bell shaped curve. Sister-sister heights correlate very well and slightly better than brother-brother heights. Both correlate to a greater degree than sister-brother heights.

The weight of the child is again a reflection of his parents' genes, to some extent, and the eating habits of his population culture. A lean body mass (LBM) as determined by boney chest breadth (by x-ray examination)

reflects the parental genes in that the average of the parents' LBM measures correlates with the child's LBM. If the parents' LBM is large, they will have large children by LBM and weight; if small, the child will be small for LBM and weight. Reflecting a combined genetic-environmental interreaction is the observation that if both parents are obese, the child has an 80 per cent chance of being obese; if one parent is obese, there is a 50 per cent risk for obesity in the child; and if both parents are thin, there is a 20 per cent chance of obesity in the child.

Age of sexual maturation is primarily genetic in origin. Mothers and daughters will have similar ages of onset of menses but sisters will have even closer correlation for the age of menarche. In addition, there are families in which male and female early or late sexual maturation are consistent features. As a reflection of genetic and environmental interaction, the obese girl has increased height and earlier menses as compared to her chronologic age cohorts. Lastly, a primarily environmental effect, which is probably a reflection of better nutrition, is the earlier onset of menses in girls this century as compared to children in the last century.

Head circumference is an accurate measure of the amount of brain tissue and its development. The head circumference of the child is a reflection of his parental genes, with the parents having small to large normal head sizes with normal amounts of brain material. Once again, the plus or minus two standard deviation curve allows for normal variation.

Emotional Relationships and Behavior

Schizophrenia has a large genetic component. An even greater genetic effect is seen in manic depressive psychosis. These aspects have been proved by studies of identical twins who have been reared apart from one another. However, a question arises as to the extent of the genetic basis for non-psychotic emotional disturbance or normalness, as compared to the greater area of environmental modification. Since fetal organs are functioning *in*

utero, (e.g., heart, kidney, liver, and so on) it seems unlikely that the largest organ of the body—the brain—with 10 billion neurons by the time of birth, does not have some *in utero* function as well.

Birch and his colleagues have developed a semiquantitative system for evaluating newborns' and young infants' behavior. We know that some babies are "smiley," happy, pliable, and pleasant from the time that they are born. Others are intense, crying, unhappy newborns and young infants. Dr. Birch's group scored the qualities that reflected the babies' personalities, such as sleep and wake cycles, adaptability, mood, intensity of reactions, distractability or persistence of behavior, levels of activity, and thresholds for responsiveness to environmental stimuli.³ They subsequently made evaluations as to how the child's behavior was modified during his growth process by increasing socialization and environment. It was found that at school age, of those children who had "mother-killing features of organization" as a newborn infant (i.e., arrhythmic, intense, negativistic moods, non-distractable, non-adaptable) one third had emotional disturbances. The question arises as to whether this is abnormal in nature or is, in reality, an extreme normal variant in a plus or minus two standard deviation bell curve.

Mental Development

We can all recognize the qualities of high intelligence in an individual, whether or not he is highly educated, but difficulties arise in quantitating these factors. The qualities of intelligence have to do with abilities for abstraction, synthesis, foresight, problem solving, learning from experience and application of that learning, i.e., "common sense." Quantitation is complicated by the differences in life experiences in various cultures and the utilization of intelligence tests derived from other cultures. For example, a physician colleague of mine took an IQ test prepared by the people from Watts and scored in the vicinity of 15. I dare say that I would have an even lower score. In any

event, the quantitative IQ of the child will be in the range of plus or minus 15 points of his parents' IQ. Genetically, the rates of intellectual growth are fairly constant. Fifty per cent of what is measured as adult IQ is developed by the age of 4 years and 80 per cent by 8 years. This correlates well with the fact that most of the brain weight has developed by 2 years of age and 95 per cent of the adult brain weight is attained by the age of 6. In essence, mental ability is a reflection of numbers of brain cells and their interconnections.

During intrauterine life and early infancy there are increasing numbers of brain cells being formed. For both animal and human,⁴ this proliferation of numbers of cells can be markedly interfered with *in utero* and during the early months of postnatal life by malnutrition. Of major importance is the fact that such a reduction in *numbers* of cells is irreversible. If malnutrition supervenes after 6 months to one year of age, there will be normal *numbers* of brain cells but they will be of reduced *size*. This aspect is reversible with good nutrition and is reflected by a rapid increase in head circumference, i.e., brain weight, so that a normal intellectual potential can still be expressed. The worst damage is incurred by combined prenatal and early postnatal interference.

Besides brain development, the child represents the superimposition of environmental intellectual stimulation at sensitive periods with resultant development of personality and ability to learn, i.e., the development of motivation, achieving processes, "go-getter" attitudes, and so on. Of course, this is partly determined by the genetic background of the parents.

The investigations of developmental testing in normal children have demonstrated that the environment has a considerable influence on the results. Better nutrition in the modern normal child has led to earlier developmental maturation. Infants are performing test items one to two months earlier than the children of the previous generation.

The genetic influence on normal developmental test results can be illustrated by the fact that girls are ahead of boys in most tests for the first two years of life. This occurs mainly in the area of speech, with girls talking earlier and a great deal more. This difference persists throughout their life span. Boys and girls are equal in development of motor behavior. Boys are ahead of girls in perceptual motor behavior, such as form perception, copying circles, and the like. Mental development of the offspring of parents with a large LBM occurs at a faster rate than the development of the children of parents with a small LBM. In addition, the genetic influence on development is revealed by good correlation between like sex siblings, especially sister-sister.

In the educational sphere, one can observe these genetic and environmental factors for mental and personality development continuing throughout life. Once again, the problems that occur require definition with regard to the amount of genetic or the amount of environmental influence. As an example, word blindness or dyslexia or reading disability—or any term you prefer—occurs in 16 per cent of the males but only 4 per cent of females. Thus, there is some genetic basis for this disability as revealed by sex incidence differences. In addition, maturation occurs in some of the children with a "catch-up" period at 8 to 9 years of age; and there is frequently a positive family history for the disorder. One is forced to speculate that this is of genetic origin with a slow maturation of certain biochemical processes. However, in the group of dyslexic children, we encounter those with environmental causation in that there is an increased incidence of the disorder in the children from lower economic and social backgrounds and reduced home reading interest. Another environmental type of dyslexia is found in the child with minimal central nervous system damage and normal IQ.

Community Cultural Aspect

We find varying incidences of genetically caused diseases in specific populations, e.g.,

pyloric stenosis, club feet, central nervous system disease, and so on, in Caucasians, Negroes, Orientals, and other groups. There are normal ethnic genetic variations for height and weight throughout the world. Japanese measurements differ from standard Swedish measurements. However, there has been no variation between populations with regard to the plus or minus two standard deviation curve for average head circumferences (without malnutrition detriments) throughout the world.⁵ Thus, brain weights, brain development, and intelligence would appear to be equivalent for all ethnic populations of the human race.

Speculations

The genetic potential is never fully realized for normal, deleterious and beneficial genes. The expression of these genes is always modified by the environment. As a part of the environment is improved (by reduced infectious disease, improved nutrition, and so on) there is an increased expression of beneficial genetic components and a reduction in the expression of deleterious genes. Environmental pollution will always produce more harmful effects than beneficial ones. In any case, environmental improvement or worsening really means that the environment is *changing*. This, in turn, implies that there is a chance for the expression of hidden genes—we are all different—some of which have a better survival value in the *new* environment, whether or not that particular gene is harmful at present or will be beneficial four to five thousand years from now. The important feature is that with the change in environment, the plus or minus two standard deviation

"normal" distribution bell curve will also change so that the future norm will be quantitatively different from the present one.

Today's children have increased intelligence, are larger in height and weight, and have an earlier age of sexual maturation, meaning that the female will have an increased span of years for bearing children. Children today are experiencing an increased length of time devoted to adolescence and emotional immaturity which implies adventurousness and exploration of multiple experiences; and they can expect an increased total length of life in good physical condition. These features can be projected as leading to a "better life" on this planet. On the other hand, they can also be projected as preparation for prolonged space voyages to other worlds in an escape from an overpopulated, environmentally polluted, and dying planet. Genetically, there is the potential for future generations of our children to accomplish both projections. Unfortunately, the postscript is *only* if the decaying moral and physical environment doesn't eliminate all genes first.

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100 Bergen Street

205th Annual Meeting

May 15-18, 1971

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

December 20, 1970

A regular meeting of the Board of Trustees was held on December 20, 1970 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Medicredit Bill . . . Received as informative a statement from President Satulsky that a committee consisting of A. Guy Campo, M.D., Charles L. Cunniff, M.D., and David Eckstein, M.D. had been appointed to study the Medicredit Bill. This is H.R. 18567, an AMA sponsored health insurance proposal combining voluntary insurance with a tax credit proposal whereby individuals, instead of receiving money or free medical care, may take a tax deduction. The Committee will report findings and recommendations to the Board at the February meeting.

Physicians' Associates . . . Referred to the Committee on Medical Education, for study and recommendation, a proposal of the College of Medicine and Dentistry at Rutgers (in cooperation with the Livingston College of Rutgers University) to establish a Department of Community Medicine and to establish a baccalaureate program for physicians' associates.

Commission on Reorganization of State Government . . . Received the announcement of President Satulsky that he has appointed the following to study and make recommendations (at the request of Minority Leader Senator Crabel) on the Management Study Commission Report on Reorganization of State Government:

Louis F. Albright, M.D., Chairman
Edward G. Bourns, M.D.
Harold L. Colburn, Jr., M.D.
I. Edward Orna, M.D.

Council on Mental Health . . . Approved the report of the December 9th meeting of the Council on Mental Health, including the following recommendation:

That MSNJ recommend to the Governor that each state hospital establish programs devoted to the treatment of alcoholics, plus clinic facilities for continued care; and that these programs be established on the basis of appropriate funding.

Medical Defense and Insurance . . . Approved the report of the December 6th meeting of the Committee on Medical Defense and Insurance, including the following recommendation:

That the Loss Control Program approved in October 1968 be appropriately amended (as outlined below).

1. Add item D. (7) (a) If the attorney cannot locate an expert medical witness to testify for defense, the committee must furnish a witness or reverse its decision to defend.

2. Change item D. (6) (c) Defense with vote of 75 per cent or more of the members present. If vote is less than 75 per cent, settlement must be authorized.

3. Add item D. (5) (a) If the committee fails to follow the attorney's recommendation based on information or opinion not related to the medical question, MSNJ's official broker will be advised. He will discuss the controversy with the committee chairman. If it is not satisfactorily resolved, he will refer it to the Committee on Medical Defense and Insurance for final determination.

4. Add item D. (8) The insurance carrier may make settlement without prior review by the committee up to \$500 in any claim in which there is malpractice in the opinion of the claim manager, and written consent of the insured physician is obtained.

5. Add item B. (3) If during trial, the defense is damaged by unexpected acceptable adverse testimony or other important adverse conditions, the attorney, with permission of the insurance carrier and written consent of the insured physician, may settle the case as contrary to the committee's decision.

. . . Suggested that an informational bulletin be issued to the county Medical Review and Advisory Committee chairmen delineating the procedures to be followed and apprising them of the fact that county committees have recourse to the State Society Committee on Medical Defense and Insurance when county committees do not agree on the procedures to be followed.

Publication Committee . . . Approved the following recommendation concerning filler statements relating to advertising that may appear in *The Journal* from time to time:

That the Board of Trustees endorse a general approval of the policy suggested (as outlined below).

Note: The above recommendation resulted from consideration of a complaint from a member-physician who objected to filler items such as "Patronize Our Advertisers" and to any indication that an advertisement in *The Journal* has been "approved."

In a memorandum to the Board, from the Editor of *The Journal* it was related that practically all of the national advertising for *The Journal* comes through the State Medical Journal Advertising Bureau. The companies that advertise prepare a plate from which the actual advertisement is made. This is uniformly sent to all the state journals that belong to SMJAB. SMJAB screens the ads before they are sent to the state journals. Each state journal, including MSNJ's, has a publication committee which further screens the copy. In a sense, therefore, the advertisements have been "approved."

The confusion develops because *The Journal* is approving placement of the ad, not approving the product. The Editor further stated that the complaining physician "may be right in suggesting that this distinction is a bit subtle—by indicating that the copy has been approved for publication as an advertisement, we are not necessarily putting a seal of approval on the product. Obviously, no medical journal has facilities for checking the pharmacologic, therapeutic, or clinical merits or disadvantages of the drugs advertised."

The physician's grievance was taken up by the Committee on Publication and it is their consensus that *The Journal* should discontinue making statements which imply that the Society is endorsing any of the pharmaceuticals or other products or services advertised. However, the Committee does not wish to discontinue the brief filler statements such as "Patronize Our Advertisers" or "Patronize Our Advertisers—They Merit Your Support," and believes that format and type styles for

these must be at the discretion of the editorial office.

Emergency Medical Care Exercise . . . Approved the following recommendation of the Committee on Emergency Medical Care:

That The Medical Society of New Jersey co-sponsor—with the Division of Emergency Health Services of U.S. Public Health Service and the New Jersey Hospital Association—an annual statewide exercise for the next five years to cover the whole range of emergency medical care.

Note: The first exercise will be conducted in the spring of 1971 and will be concerned primarily with communications.

Priority of Emergency Medical Care . . . Approved the following recommendation of the Committee on Emergency Medical Care:

1. That the following statement be adopted by the Board of Trustees:

That emergency medical care be given a high priority on the National level and that the Federal authorities should provide adequate funds to administer a comprehensive program of emergency medical care.

Project Hope/Vietnam . . . Approved the recommendation of the Committee on Project Hope/Vietnam that a \$1,000 fellowship be awarded to John J. Thompson, M.D. (Essex County) for his tour of duty in Vietnam, December 30, 1969 to March 2, 1970.

Utilization Review . . . Directed that a communication be sent to component medical societies eliciting support for the proposal that Blues Cross-Blue Shield, MSNJ, and NJHA cooperate in setting up a panel of physicians to review and evaluate utilization review mechanisms in New Jersey hospitals by means of on-site inspections of charts of hospitalized patients.

Medical-Legal Liaison Committee . . . Approved the report of the December 9 meeting of the Medical-Legal Liaison Committee, including the contained recommendations:

1. That each county bar association and component medical society be urged to adopt a cooperation agreement. (If they do not already have one or if their current agreement does not function as well as desirable, it is suggested that they utilize the format of the Morris County Agreement with such modifications as are appropriate locally.)

2. That at least once per year each county bar association and the respective component medical society hold a joint social meeting.

Physician's Welfare Fund . . . Approved the report of the Committee on Establishment of a Physicians' Welfare Fund, including the following recommendations:

1. That a program known as the "Physicians' Relief Fund of The Medical Society of New Jersey" be established.

2. That it be administered by a committee of The Medical Society of New Jersey, similar to that of the Medical Student Loan Fund, with each judicial district represented, and with a member of the staff assigned to be responsible for the maintenance of records and for supervision of the administration of the Relief Fund.

3. That the Committee consist of five (5) members, appointed from the respective judicial districts by the Board of Trustees; and that in addition to its normal administrative powers, it be authorized to appoint one or more "Fund" representatives from each of the component societies. (The Board empowered the President to appoint such a committee.)

4. That the Committee, as its first order of business, be charged with the responsibility of drafting a statement of purpose and policy to govern the operations of the Fund, together with suggested rules and regulations concerning financing, eligibility, and bestowal and limitations of benefits—all for submission to and clearance by the Board of Trustees and/or the House of Delegates.

5. That the Fund be financed by an initial allocation determined by the Committee on Finance and Budget in an amount not to exceed \$35,000.

Board of Medical Examiners . . . Submitted the following candidates (listed in order of preference) to the Governor to fill the term of Ralph M. L. Buchanan, M.D. on the State Board of Medical Examiners (present term expires January 8, 1971):

Ralph M. L. Buchanan, M.D.
Rudolph T. DePersia, M.D.
Richard B. Berlin, M.D.

Council on Legislation . . . Appointed Leon A. Fraser, M.D. of Mercer County to fill the vacancy (3rd District, term expires 1973) on the Council on Legislation until the 1971 Annual Meeting.

New Jersey State Society of Anesthesiologists . . . Received a report from the New Jersey State Society of Anesthesiologists and directed that the Board's actions on items presented

for its consideration be transmitted to the Society of Anesthesiologists:

1. To change the policy of supporting the Medical-Surgical Plan in its non-payment to non-participating physicians; that is, to accept an assignment of benefits.

. . . To this the Board pointed out that the policy decision was affirmed by the House of Delegates and could be changed only by that body.

2. To investigate the influence of Blue Shield upon the Medicaid Plan, if such were the case.

. . . The Board called attention to the fact that compensation under the Medicaid Program in New Jersey is based upon a percentage of usual and customary fees and not upon the Blue Shield schedule of payments.

3. To permit publication of the Medicaid fee schedule.

. . . The Board indicated that there is no uniform Medicaid fee schedule in New Jersey, as the answer to #2 above indicates.

4. To reconsider its support of the 1956 fees for New Jersey Compensation in New Jersey for anesthesia.

. . . This matter has been repeatedly reviewed and reported upon, most recently—as reported in the January 1969 issue of *The Journal*—by the Council on Medical Services and approved by the Board of Trustees. The State of New Jersey, in order to allow its employees the free choice of physician will compensate all treating physicians according to an established fee schedule and will not pay the usual and customary fees paid by other employers. Accordingly, our members have been advised as follows: "The physician who will not settle for less than his usual and customary fee should not treat a State employee for a compensation related injury or illness or should, in the alternative, prior to instituting treatment, inform the patient that he will hold

him personally accountable for the difference between the State fee schedule and his usual and customary charges."

5. To use its influence and powers to mediate and aid the New Jersey State Society of Anesthesiologists in its, to date, unsuccessful attempt to update the Blue Shield fee schedule to a 1970 level.

... This matter, the Board was informed, is in process of negotiation between representatives of the Medical-Surgical Plan and the anesthesiologists.

6. To survey all doctors in the state as to their feelings and reasons for belonging to the Blue Shield Program, and to verify if the plan is truly a doctor's plan.

... The Board called attention to the fact that the Medical-Surgical Plan of New Jersey was brought into being by The Medical Society of New Jersey, and that presently approximately 80 per cent of all physicians in the state are enrolled as participating physicians of the Plan.

7. To encourage the appointment of a non-participating physician to the Board of Trustees of Blue Shield, in order to have representation of those who do not belong to Blue Shield.

... This, the Board pointed out, is not within its purview. Such decision belongs to the Board of Trustees of the Medical-Surgical Plan.

PATRONIZE
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Treatment Of Persons Bitten By Animals

The following is a release from the New Jersey State Department of Health, James R. Cowan, M.D., Commissioner, and is published at the request of the Department.

Confirmation of rabies in a bat captured in New Jersey in 1960, and an average of sixteen bats each year since then, establishes the presence of rabies virus in our state. Rabies occurs regularly in several species of animals in our neighboring states. Pets, livestock, or wild animals may at any time become infected from these sources. This accentuates the importance of swift and effective treatment of humans bitten by animals. The following information is offered for the guidance of physicians.

Reporting Animal Bites—Under Revised Statutes 26:4-79, 80, and 81, the name, age, sex, and location of any person bitten by any animal must be reported to the local board of health by the physician attending the person bitten, by the parent or guardian of a child bitten, or by an adult bitten when no physician attends.

It is expected that investigation to determine the exact circumstances of exposure will then be conducted by the health department of the municipality concerned. Further consultation will be provided by the State Department of Health.

Any dog or cat which bites a person should be caught alive if possible, dead if necessary. The live dog or cat should be confined for at least ten days in an enclosure suitable to prevent escape. Local boards of health have authority to confine a dog or cat which has attacked or bitten a person. Confined dogs or cats should be observed by a veterinarian to detect signs of possible rabies. If a dog or cat is confined by some person not qualified to detect such symptoms, the dog or cat should be examined at once by a veterinarian, if it shows any of the following: a change in disposition, unusual "nervousness" or irritability.

ty, a tendency to bite without provocation, a change in voice, dropping of the lower jaw, weakness of the legs, anorexia, or twitching of muscles.

The State Department of Health recommends that a wild animal which bites a person be sacrificed immediately for laboratory examination. The ten-day observation period for dogs and cats is based on the knowledge that rabies virus appears in the saliva of a dog or cat only a few days before the animal dies of rabies. It has been demonstrated that bats can live for much longer periods after the appearance of rabies virus in the saliva. The relationship of death to the appearance of rabies virus in the saliva of other animals is not known.

If a wild animal has been maintained in captivity (or any pet other than a dog or cat), the responsible health official must decide whether to observe or sacrifice the animal. The decision may be based on the history of the animal and the circumstances of the bite.

Submission of Brain for Laboratory Examination—Laboratory examination of the brain is indicated for an animal which has bitten a person, when the animal dies during the period of observation or when the animal is sacrificed as described above.

The specimen to be submitted is the head of a small animal such as dog, cat or mouse, the brain of a large animal such as horse, cow or sheep; or the entire bat. The specimen should be carefully packaged and refrigerated. Information accompanying the specimen should include name, address, and telephone number of the person bitten and the attending physician, the date of the bite, and the description of the animal.

The specimen should be delivered by messenger to the laboratory of the State Department of Health in the circular building next to the Health-Agriculture Building on John Fitch Way, Trenton. The messenger will get directions from the clerk in the lobby of the

Health-Agriculture Building during business hours, or from the watchman at other times. Responsibility for delivery of animal heads to Trenton rests, in order, with: *first*, the owner of the biting animal; *second*, the person bitten or a member of his family; *third*, the Local Board of Health. State Police are not normally to be expected to transport specimens.

The prompt examination of any specimen is a necessity; in rabies, it is of extreme importance. Make every effort to have the specimens submitted as quickly as possible. The State Department of Health will cooperate by accepting specimens any hour of any day, and by having prompt examination made. Time is critical. If antirabies serum is indicated, it should be used within 72 hours.

Post-Exposure Treatment—Early, vigorous, local cleansing is of primary importance in preventing infection. Wash the wound meticulously with soap or detergent and flush thoroughly with water. The wound should *not* be immediately sutured, unless this is strongly indicated as part of necessary surgical procedures. If the recommended treatment includes the use of antirabies serum, part of the serum dose should be infiltrated about the wound. Apply antiseptic after the foregoing procedures. Cauterization is not usually recommended. If the physician feels that tetanus prophylaxis is indicated, it should be instituted by the use of a booster dose of tetanus toxoid.

The manufacturer's recommendations should be consulted prior to use of serum and vaccine. Antirabies serum, if used, should be administered in a dose of 40 international units per kilogram of body weight.* Sensitivity of the patient to the serum should be tested before it is used. A portion of the dose should be infiltrated around the bite. Under no circumstances should additional serum be administered. Subsequent doses may interfere with the response to rabies vaccine.

Duck embryo rabies vaccine is prepared for subcutaneous injection in doses of one cubic

* This amounts to 18 units per pound of body weight.

centimeter daily for 14 days. If serum is followed by a full course of vaccine, two supplemental doses of vaccine should be administered at 10 and 20 days following completion of the usual vaccine schedule.

Procurement of Serum—Physicians may obtain antirabies serum from the warehouse of the State Department of Health in the

Health-Agriculture Building, John Fitch Plaza, Trenton. A written order from the physician is required. Arrangements may be made by calling one of the following:

	<i>Business Hours</i>	<i>Other Times</i>
Mr. Lyle Cook	(609) 292-5570	(609) 882-1944
Dr. William J. Dougherty	(609) 292-4046	(609) 396-6067
Mr. Edward A. Osvai	(609) 292-5514	(609) 799-1130

GUIDE FOR SPECIFIC POST-EXPOSURE TREATMENT Adapted from World Health Organization Guide

Nature of Exposure	BITING ANIMAL*		Recommended treatment in addition to local treatment)
	At time of exposure	During observation period of 10 days	
I. No Lesion: Indirect Contact	Rabid	—	None
II. Unprovoked Bites (1) mild exposure	a. Healthy	Healthy	None
	b. Healthy	Clinical signs or proved rabid.	Start vaccine at first clinical signs in animal.
	c. Signs suggestive of rabies	Healthy	Start vaccine immediately. Stop if animal is normal on 5th day after exposure.
	d. Presumed rabid, escaped or unknown	—	Start vaccine immediately
	e. Killed	—	Start vaccine immediately.*** Discontinue with negative lab. report.
	f. Bat	—	Vaccine regardless of lab result.
(2) Severe Exposure (multiple, or face, head or neck bites)	a. Healthy	Healthy	None
	b. Healthy	Clinical signs or proved rabid.	Start serum and vaccine at first sign of rabies in biting animal.
	c. Signs suggestive of rabies	Healthy	Serum immediately followed by vaccine; vaccine may be stopped if animal is normal on 5th day after exposure.
	d. Presumed rabid, escaped or unknown	—	Serum immediately followed by vaccine.
	e. Killed	—	Start vaccine immediately.*** Discontinue with negative lab. report.
	f. Bat	—	Vaccine regardless of lab. result.
III. Bites where Provocation Exists	a. Healthy	Healthy	None
	b. Healthy	Clinical signs or proved rabid.	Start vaccine at first signs of rabies in animal.
	c. Signs suggestive of rabies	Healthy	Start vaccine immediately. Stop if animal is normal on 5th day of exposure.
	d. Escaped or unknown	—	None.**
	e. Killed	—	None, unless lab. reports evidence of rabies.
	f. Bat	—	Vaccinate regardless of lab. result.

*Rats, mice and hamsters appear to be of very little importance as transmitters of rabies in this area. Persons bitten by these animals should not receive specific post-exposure treatment, unless the reported activities of the animal are so distinctly unusual as to be highly suggestive of rabies.

**This recommendation is predicated on the fact that the incidence of rabies in New Jersey is so low that the possibility of adverse effects from vaccination outweighs the risk of rabies. In the event there is a change in the incidence of rabies in this State, all physicians will be so notified and recommendations appropriately modified.

***Physician may elect to delay administration of vaccine if animal brain can be delivered promptly to laboratory.

Procurement of Vaccine—Rabies vaccine may be obtained from the State Department of Health as listed on p. 151 and from the following biological distributing stations:

BIOLOGICAL DISTRIBUTING STATIONS
Rabies Vaccine for Humans

<i>County</i>	<i>Municipality</i>	<i>Location</i>	<i>Telephone</i>
Atlantic	Atlantic City	Board of Health Municipal Building	(609) 344-2121
Bergen	Hackensack	Hackensack Hospital	(201) 487-4000
Bergen	North Arlington	Board of Health Municipal Building 10 Beaver Avenue	(201) 991-4367
Camden	Camden	Department of Health Municipal Building	(609) 964-9000
Camden	Haddonfield	Southern State Health District 89 Haddon Avenue	(609) 429-7550
Cumberland	Vineland	Newcomb Hospital	(609) 691-9000
Essex	Bloomfield	Board of Health Municipal Building	(201) 743-4400
Essex	East Orange	Board of Health 143 New Street	(201) 673-4100
Essex	Newark	Board of Health 94 William Street	(201) 624-6400 after hours (201) 643-8800
Hudson	Jersey City	Board of Health Building C, 8th Floor Medical Center	(201) 433-7000
Hudson	Kearny	Board of Health 645 Kearny Avenue	(201) 991-2700
Hunterdon	Flemington	Hunterdon County Medical Center	(201) 782-2121
Mercer	Trenton	State Department of Health John Fitch Plaza	(609) 292-5514 after hours (609) 392-2020
Middlesex	New Brunswick	Health Department City Hall	(201) 249-0911
Middlesex	Perth Amboy	Board of Health 44 Market Street	(201) 826-0290
Middlesex	Woodbridge	Board of Health 800 St. George Avenue	(201) 634-4500
Monmouth	Asbury Park	Board of Health 913 Sewell Avenue	(201) 775-0196 after hours (201) 774-7137
Monmouth	Long Branch	Board of Health Garfield Court	(201) 222-7000
Morris	Dover	Board of Health Municipal Building	(201) 366-2200
Morris	Morristown	Board of Health 29 Ann Street	(201) 538-3707
Morris	Succasunna	State Health District 61 Sunset Strip	(201) 584-8121
Ocean	Lakewood	Board of Health City Hall	(201) 383-2121
Passaic	Paterson	Board of Health City Hall	(201) 471-3300 after hours (201) 684-0097
Somerset	Somerville	Somerset Hospital	(201) 725-4000
Sussex	Newton	Newton Memorial Hospital	(201) 383-2121
Union	Cranford	Board of Health Municipal Building	(201) 276-8900
Union	Elizabeth	Board of Health Municipal Building	(201) 353-6000 after hours (201) 351-1644
Union	Plainfield	Board of Health Municipal Building	(201) 756-0704
Warren	Hackettstown	Bach's Drug Store 149 Main Street	(201) 425-5949
Warren	Phillipsburg	Warren Hospital	(201) 859-1500

Behind The Drug Scene

(This column is prepared by Stanley Einstein, Ph.D., Coordinator, Drug Abuse Project, Martland Hospital Unit, NJCMD, Newark, and Executive Director, Institute for the Study of Drug Addiction, New York City.)

Methadone Treatment Revisited

The Third National Conference on Methadone Treatment was held last November in New York City. More papers were presented during this conference than ever before, with less discussion and a more heterogeneous audience. These points tend to reinforce the apparent change in the status of methadone maintenance from that of an *experimental* treatment procedure necessitating more investigation to that of a *proved* treatment modality. At the closing of the 1969 conference one of the participants raised a serious issue: Was the meeting a rally or a scientific conference? Although the 1970 conference ended with statements concerning a fourth conference, it too had served to be a rally.

The first panel, introduced by Dr. Richard Phillipson,* warned the audience not to fall into the trap of furthering methadone maintenance without having hard data to substantiate its increased use. "Two of the major claims for the efficacy of methadone maintenance treatment," he said, "are that it results in a reduction in criminality and an increase in employment. But it is difficult, if not impossible, to find today, when some methadone maintenance programs have been in operation for over five years, any really hard data to support the claims of a reduction in criminality or of an increase in long-term employment and support of self and family."

The major problem, which continues to be the model for the nation, is the Dole-Nyswander one from New York City, evaluated by Dr. Frances Gearing.† Criteria for success in this program are: drug abstinence, fewer arrests, increased social productivity (patients should be working, in training programs, or in school) and willingness to accept help for alcoholism and other psychiatric problems.

Based on a population of almost 3,500 narcotic addicts who were screened into the program (with median ages of 33 to 35) the following important findings were reported:

1. One per cent still use heroin regularly, based on urine testing
2. Eight per cent have problems with alcohol
3. Ten per cent have problems with barbiturates, cocaine, and amphetamines
4. Use of drugs and alcohol are major reasons for discharge from the program
5. Six months following discharge from the program a third of the patients were drug free. A year or more after discharge, 18 per cent were drug free
6. Arrests and incarcerations were dramatically lowered for methadone maintenance patients
7. Employment status increased and support by welfare and others decreased dramatically from entrance into the program through the first six months and then plateaued out for the next three years. Change in school status is only minimally effected
8. Whites and blacks are almost equally represented in this program. Spanish-speaking addicts make up fewer than 20 per cent of the patients in treatment.

Given a selected patient sample to begin with, the achievement of the project's success criteria leaves much to be desired. None of the results can be directly related to methadone maintenance specific dose levels on which other auxiliary services were involved. Dr. Jaffe, directing the Illinois Program, reminded the audience that the demand for specific methadone maintenance criteria, such as the ones used in New York may be met at the cost of high group attrition.

The issue of criteria, their appropriate selection given a specific population and the cost of their achievement for all concerned, is really the central issue in this contemporary form of treating the narcotic addict. The achievement of criteria in contemporary programs is not uniform and it is less than gratifying. Treatment criteria are arbitrary. Their achievement is based on their meaningfulness and achievability for the patient, and their acceptability to all participants of the treat-

*Associate Director, Division of Narcotic Addiction, National Institute of Mental Health.

†From Columbia University School of Public Health.

ment system. In this light, we can look at methadone maintenance in a more realistic fashion.

Whom is methadone maintenance for?

As of now, we don't know in any predictive sense and have some inklings only retrospectively.

Is low or high dose treatment the most efficacious?

The dose must be related to the patient's present as well as to his achievable state of functioning derived from base-line evaluation data. The dose is not determined by a program's commitment to a particular dose philosophy. The critical issue may be the alleviation of the person's narcotic hunger, rather than methadone's blocking effect.

At what age should a person be put on methadone maintenance?

The issue of addicting a teenager (or using methadone as a last resort with a teenager) is a moralistic-philosophic one at its core, not withstanding the rationalizations put forth in defense of the rather older "median age" for all contemporary programs. If the treatment is efficacious we should use it. If it works for only certain people, we should limit its use to those people. If we insist on using a treatment without knowing beforehand whom it will work for, why pick an age as a differentiating factor? Remember that most of the contemporary programs have no budget for doing the research that might answer this plus other vital questions.

Do side effects mitigate against wide use of methadone maintenance?

Usually side effects are viewed in terms of number of patients reporting them and the extent to which they interfere with the patient's daily functioning. One might defend the sexually potent treatment agent's position that impotence in the methadone-maintained patient is a minor problem. But side effects relating to substitution of drugs may not be as easy to defend. Some researchers feel that most side effects are unrelated to drug dose effects but may be related to withdrawal phenomena.

Can intermittent and/or regular heroin use be significantly decreased for the active

methadone maintenance patient?

Only time will tell. Perhaps splitting doses (morning and evening) may prevent heroin use which most often occurs in the evening when the effects of methadone may be wearing off.

What auxiliary services should be available for methadone maintenance patients?

The obvious answer is—those that they need. To meet these needs we would have to hand-tailor treatment which rarely occurs in this field. Of 47 existing programs, 6 are inpatient, 19 outpatient, the remainder are a combination of both. Functionally this means that the program a person is in decides what he is receiving rather than what his needs are deciding the program he is to enter.

When is methadone maintenance contraindicated?

The immediate answer is when it doesn't work. Lesser but relevant issues may include: when prevention is the goal for non-narcotic users, for young addicts, and for addicts who don't want it.

The medical practitioner, whether based in an institution or in private practice, must develop the necessary critical skills to begin to evaluate the strengths and limitations of this treatment modality and his role in such treatment. Throughout the country, there are some 9,000 methadone-maintenance patients, and it is the hope of the New York group to extend their present 4,000 patients to 25,000 in a few years. For this 9 million doses of methadone will be needed annually at a yearly program cost of \$100,000,000.

The New York evaluation committee recommends the evaluation of long term effectiveness of methadone treatment, training of staff members, non-use of methadone maintenance by private physicians, and the development of a pilot study using private physicians for narcotic addicts who need only minimum auxiliary services.

All of this leads me to ponder a recent sign I saw—*Grass is Nature's Way of Saying High*. What is the physician saying when he offers methadone? Your comments would be of great interest.



CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

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Atropine sulfate 0.025 mg.

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Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addictive drugs. Recommended dosages should not be exceeded, and medication should be



kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant

urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo. ... ½ tsp. ^q t.i.d. (3 mg.)
 6-12 mo. ... ½ tsp. q.i.d. (4 mg.)
 1-2 yr. ½ tsp. 5 times daily (5 mg.)
 2-5 yr. 1 tsp. t.i.d. (6 mg.)
 5-8 yr. 1 tsp. q.i.d. (8 mg.)
 8-12 yr. 1 tsp. 5 times daily (10 mg.)
 Adults: ... 2 tsp. 5 times daily (20 mg.)
 or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

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Gordon Scholarship Award

The second winner of the Gordon Medical Scholarship is Robert Petrusky of Linwood, New Jersey. He thus receives the 1970 Dr. Benjamin Lee and Dorothy Gordon Memorial Scholarship. Mr. Petrusky, a Phi Beta Kappa graduate of Rutgers, has received \$5,000 to attend the Medical School of the University of California. This has been awarded by the Scholarship Committee of the Atlantic County Medical Society.

The Dr. Benjamin Lee and Dorothy Gordon Memorial Scholarship has been used as a model to encourage physicians to donate similar \$5,000 scholarships through their county medical society to enable worthy local premedical students to attend medical school.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during December, 1970:

	1969 December	1970 December
Aseptic meningitis	20	13
Primary encephalitis	1	2
Hepatitis: Total	234	363
Infectious	194	283
Serum	40	80
Malaria: Total	10	12
Military	8	12
Civilian	2	
Meningococcal meningitis	5	15
Mumps	251	420
German measles	21	13
Measles	94	4
Salmonella	26	104
Shigella	82	35

Rubella Immunization in New Jersey

The Vaccination Assistance Program began in 1970 with the goal of making rubella vaccine available to the parents of every child in New Jersey between the ages of one and ten. The effort made by Division staff to accomplish this goal is described under three headings as follows: (1) "Model Cities" Programs, (2)

Community sponsored programs, (3) State sponsored county-wide programs.

In the early phase of rubella immunization activities vaccine supplies were limited, and restricted priorities as to vaccine use had to be imposed. It was, therefore, decided to concentrate the limited available vaccine among school children in grades kindergarten through four in selected urban areas. Cities which had received Model Cities planning grants were chosen for this first phase of the immunization program.

The "Model City" phase of the rubella program began in Hoboken on October 6, 1969, and involved seven model cities. The vaccine was offered to all kindergarten through fourth grade children in the public and parochial schools. Project staff utilizing hypodermic jet injector equipment administered the vaccine. Physician coverage was provided by the local community. In this fashion, rubella vaccine was administered to 79,030 (68 per cent) of the 115,399 kindergarten through fourth grade children in the model cities.

Early in 1970, it was realized that school-based programs, although efficient in terms of proportion of school children immunized, would not reach sufficient numbers of children without additional measures. Therefore, it was decided to expand the format. After the Board of Trustees of The Medical Society of New Jersey endorsed the concept of mass rubella immunization programs, the medical societies in each of the 21 counties were approached. They similarly endorsed a county-wide, week-end rubella program format. The program was offered to all children ages one through ten in each of New Jersey's 21 counties, beginning on April 19 in Passaic County and ending December 6 in Hudson County. A total of 156,118 children were protected in the week-end, county-wide programs. Medical coverage for these programs was provided by local physicians who volunteered their services.

The third phase of the rubella immunization effort was the local community rubella immunization programs. Starting in the fall of 1969

and continuing through 1970, more than 200 municipalities within the state conducted programs of their own. This approach was helped in late 1969 when the State Health Department's Division of Local Health Services authorized communities who had received, but not expended, state health aid monies to utilize these funds for the purchase of rubella vaccine. In addition local communities used local funds to purchase vaccine, or asked the public to donate a fee for each child who received vaccine. These local community programs resulted in the protection of 340,527 children.

In summary, a total of 923,609 children have received rubella vaccine in New Jersey. This total, by vaccine source, is distributed as follows:

<i>Source of Vaccine</i>	<i>Number Immunized</i>
7 "Model Cities" Rubella Programs	79,030
219 Local Community Sponsored Rubella Programs	340,527
21 Week-End, County-Wide Rubella Programs	156,118
Rubella Vaccine Distributed by State Health Department through network of Biologic Distributing Stations	17,934
Sub-Total—Public Program Effort	593,609
Estimated Number Children Protected by Private Practitioners	330,000
Over-all Total	923,609

Based on July 1, 1968 population estimates there were 1,466,813 children in the age range one through ten years in New Jersey. Program statistics indicate that 923,609 or 62.92 per cent of New Jersey's eligible children have been protected against rubella.

Widows and Orphans Society

Support the Society for Relief of Widows and Orphans of Medical Men of New Jersey. Write to P.O. Box 95, Belleville, New Jersey, for information.

New Blue Cross-Blue Shield Programs

The New Jersey Blue Cross and Blue Shield Plans have announced a new three-phase program designed to counteract the rising health care costs. The program includes:

1. Introduction of new hospital outpatient and out-of hospital benefits as substitutes for costlier inpatient hospital care.
2. Employment of current cost rating for most of the Plans' enrollment with annual adjustments tied to health care costs.
3. Strengthening of the Plans' cost control programs.

The most significant portions of the new program could not have been developed without legislation introduced by Senator Wayne Dumont and signed by Governor Cahill. The new programs, several of which involve changes in the basic Blue Cross and Blue Shield subscription certificates, have been approved by the Department of Insurance.

An advisory message being sent to subscribers declares: "Governor Cahill has signed into law a series of legislative bills which permit Blue Cross and Blue Shield to streamline their methods of setting rates and to broaden the benefit base. With this new authority, we are now able to introduce programs to improve the purchasing power of your subscription dollar.

"That's important, because Blue Cross and Blue Shield must be able to cope with rising costs of care. These new programs are first steps to help achieve that end."

Some of the new programs, which do not involve changes in the subscription certificate, went into effect October 1. For legal and administrative reasons (and to assure uniform treatment of all affected members) January 1, 1972 has been selected as the effective date of all changes in benefits.

One segment of the new program is designed to reduce the frequency and the length of hospital inpatient admissions by providing less costly alternatives and includes:

Direct admission to an Extended Care Facility (ECF) or a Home Care Program, as an alternative to hospital inpatient care, will be available to experience-rated groups on request in 1971.

Post-hospital coverage in an ECF or under a Home Care program, when a patient no longer requires the complete range of services provided by a hospital, will be standard for all members after January 1, 1972.

Additional covered outpatient services without necessity of an admission as a bed patient, as presently required, will include pacemaker checkups, renal dialysis, treatment of poisoning and removal of orthopedic hardware. This also will be standard for all members after January 1, 1972.

The new law means that more members can be rated on the current cost basis which has been employed for years by all other Blue plans and commercial insurance companies. Groups of 100 or more subscribers will be able to request experience rating. By this procedure, a group's rates are determined annually to reflect the cost of its members' benefits the previous year. The schedule calls for all groups of 100 or more to be on this basis by the end of 1972.

Members who are not covered through such experience rated groups will also have their rates related to current health care costs through periodic rate adjustments that will be determined by the Department of Insurance, keyed to frequent statistical reports on trends.

Effective on January 1, 1972, Blue Cross and Blue Shield will screen out duplicate benefits for group members who are covered by more than one group health care plan. It is not unusual, with both husband and wife in many

families working, for each to have coverage under the other's group health care plan. The result can be an excess or duplication of benefits.

To avoid this Blue Cross and Blue Shield are including a Coordination of Benefits (COB) clause in their group subscription contracts which requires the carrier holding primary responsibility to pay first in the event of duplicate coverage. Under COB, no Blue Cross or Blue Shield member will be deprived of any benefits to which he is entitled, but duplication will be avoided.

The Approval by Individual Diagnosis (AID) cost control program now authorizes a specific number of days of benefits for a hospital inpatient admission on the basis of the diagnosis. This will be strengthened by an addition to the Blue Cross and Blue Shield subscription certificates enabling the Plan to require submission of evidence that inpatient hospital care is medically necessary. When a patient no longer requires the complete range of services provided by a hospital but does require some care, he can be transferred to a lower cost health care setting such as an Extended Care Facility or Home Care program.

Blue Cross will amend the subscription certificate to limit benefits involving health care facilities, equipment, or services that have been constructed or provided without approval by planning agencies because they duplicate similar facilities or services already serving the particular area. This will strengthen voluntary planning and discourage unnecessary expansion which inflates the cost of health care.

The new programs are aimed at attaining financial soundness in order to permit the Plans to continue providing benefits under the present mode of health care, and at the same time explore new systems which may ultimately prove to be more economical. Studies of such new approaches are well advanced.



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1.5 to 3 Gm. daily
successfully treats many
moderately severe
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*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



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CEPHALORIDINE

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Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

Loridine® CEPHALORIDINE



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinite® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small

number of patients. The possibility of this complication seemed to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult dosage) may be needed for very severe infection.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber stoppered; 1 Gm., 10-ml. size, rubber stoppered.

Additional information
available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY—Lawrence K. Harris, M.D., 70 Maplewood Drive, Maple Shade 08052. Dalhousie (Nova Scotia) 1965. Board eligible. Hospital or Group. Available July 1971.

FAMILY PRACTICE—Joseph P. Chollak, Jr., M.D., 132 South Franklin Street, Wilkes-Barre, Pennsylvania 18702. Jefferson 1967. Group. Available, August 1971.

INTERNAL MEDICINE—Eugene M. Kern, M.D., Box "O," Gorgas Hospital, Balboa Heights, Canal Zone. University Pennsylvania 1965. Subspecialty, gastroenterology. Board eligible. Group. Available August 1971.

OBSTETRICS AND GYNECOLOGY—Ira Bernstein, M.D., 660 East 98th Street, Brooklyn, New York 11236. New York Medical 1966. Board eligible. Partnership or solo. Available, June 1971.

Yurdakul Omay, M.D., 2106-R West Otley Road, Peoria, Illinois 61604. Ankara (Turkey) University 1956. Salaried, group, or partnership. Available.

M. H. Rezaee, M.D., 2532 Queenston Road, Cleveland Heights, Ohio 44118. Pahlavi (Iran) 1959. Board eligible. Solo, partnership, or group. Available.

OPHTHALMOLOGY—Stephen H. Franklin, M.D., 555 East William Street, Ann Arbor, Michigan 48108. NYU Downstate 1963. Solo or association. Available, March 1971.

Jose Minaya, M.D., 1106 Lyndon #10, Houston, Texas 77025. San Marcos (Lima, Peru) 1962. Board eligible. Group or partnership. Available.

Elia S. Toueg, M.D., 239 East 79th Street, New York 10021. Cairo University, UAR, 1950. Board eligible. Salaried, group, or partnership. Available December 1970.

F. K. Michail, M.D., 676 Park Avenue, East Orange, New Jersey 07017. Cairo University, UAR, 1960. Board eligible. Partnership. Available December 1970.

Donald A. Feretti, M.D., 1865 Old York Road, Abington, Pennsylvania 19001. Hahnemann 1964. Board eligible. Group or partnership. Available July 1971.

ORTHOPEDICS—Charles F. Mess, M.D., 3821 Third Street, NW, Rochester, Minnesota 55901. New Jer-

sey College of Medicine 1964. Group. Available July 1971.

OTOLARYNGOLOGY—Bardev Kapila, M.D., 142-20 84th Drive, Jamaica, New York 11435. Amristar Medical College (India) 1960. Board certified. Group, partnership, or solo. Available.

PATHOLOGY—A. Ronquillo, M.D., 310 Washington Street, Newark, New York 14513. University of Santo Tomas 1961. Board eligible. Partnership or hospital. Available February 1971.

PEDIATRICS—L. Arshad, M.D., 5735 Kings Highway, Brooklyn, New York 11203. Gandhi Medical (India) 1962. Board eligible. Group or partnership. Available.

Ayhan Erinc, M.D., 7101 South Adams Street, Peoria, Illinois 61607. Ankara, Turkey 1958. Board eligible. Group. Partnership. Emergency Room, House Physician available.

Philip H. Friedman, M.D., 287 Dickman Drive, Loring AFB, Maine 04750. NYU (Downstate) 1965. Board certified. Group or partnership. Available February 1971.

Ali Jahromi, M.D., 515 East 7th Street, Brooklyn, New York 11218. Tehran (Iran) Medical School 1968. Board certified. Solo or group. Available.

M. R. S. Parand, M.D., 11 Stephen Hopkins Court, Providence, Rhode Island 02404. Pahlavi (Iran) University 1959. Group, partnership, or solo. Available.

Leon F. Kukla, M.D., 4730 North Post Road, Indianapolis, Indiana 46226. New Jersey College of Medicine 1966. Board eligible. Group, partnership, or institution. Available August 1971.

SURGERY—P. B. Dandade, M.D., At and PO, Undri District, Buldana, M.S., India. Nagpur University (India) 1962. Board eligible. Subspecialty, thoracic and cardiovascular surgery. House physician, emergency room or group. Available as soon as visa granted—January 1971 or before if sponsored.

Mehdi B. Javan, M.D., 120 North Mole Street, Philadelphia, Pennsylvania 19102. Pahlavi (Iran) University 1961. Board certified. Subspecialty, cardiothoracic surgery. Group or partnership. Available July 1971.

Rodrigo Vilar Blanco, M.D., Doctors' Hospital, East End Avenue, New York 10028. Santiago (Spain) 1953. Board eligible. Group or partnership. Available December 1970.

Rolf H. Bessin, M.D., 6136 East Pratt Street, Baltimore, Maryland 21224. George Washington 1964. Board eligible. Group or partnership. Available August 1971.

Alan I. Josephson, M.D., 23 Parkside Drive, Hanover 07936. Tufts 1962. Board certified. Group or Partnership. Available.

Gan L. Maddinar, M.D., 41-30 43rd Street, Sunnyside, New York 11104. Nagpur College (India) 1962. Board certified. Group, partnership, or academic. Available February 1971.

Candido Deborja, M.D., 280 River Road, Apt. 4-B, Piscataway, New Jersey 08854. University of Santo Tomas 1961. Board certified. Group or partnership. Available.

ANNOUNCEMENTS

Spring Seminars In Hanover

At Hanover, New Jersey, Sandoz Pharmaceuticals is now presenting three talks of interest to the physician. The Sandoz auditorium is located at Ridgedale Avenue and Route 10.

(For information and travel directions, write to Mr. Glenn R. Short, Medical Information Bureau, 210 East 86th Street, New York 10028.) These meetings are held on Thursday evenings at 8 o'clock:

- February 25 Ophthalmologic Problems in Family Practice
- March 25 Drug Interactions
- April 22 The Disturbed Child

Clinical Application Of Basic Sciences

The Burlington County Memorial Hospital has scheduled the following programs in its "Basic Sciences and Clinical Application" series for March:

- March 4 Management of the Infertile Couple
- March 11 Sexual Problems Seen in Office Practice
- March 18 Biochemical Parameters of Aging
- March 25 The Hyperlipoproteinemias

The American Academy of General Practice gives one and a half credits for attendance at each session. All meetings convene at 3:30 p.m. in the T. J. Summey Building of the Hospital. For further information, please contact the Director of Medical Education, Burlington County Memorial Hospital, Mount Holly.

AAGP Convention

March 17 to 21, 1971 are the dates and the Host Farms, Lancaster, Pennsylvania, is the place for the next convention and graduate education course of the American Academy of General Practice. This year's meeting will include courses in sigmoidoscopy, intrauterine contraceptive devices, pediatrics, cardiac arrhythmias, and gastroenterology. For further details write to the Executive Secretary, Mr.

Arthur Ellenberger, 144 South Harrison Street, East Orange 07018.

Learning Disabilities

What is the role of the neurologist, psychologist, and pediatrician in evaluating and treating minimal brain dysfunction? One way to find out is to attend the workshop on learning disabilities at Scott Hall, Rutgers University, New Brunswick from 9:30 a.m. to 3 p.m. on Monday, March 22. Pre-registration is required. For more details, write to Learning Symposium, Box 126, North Branch, New Jersey 08876.

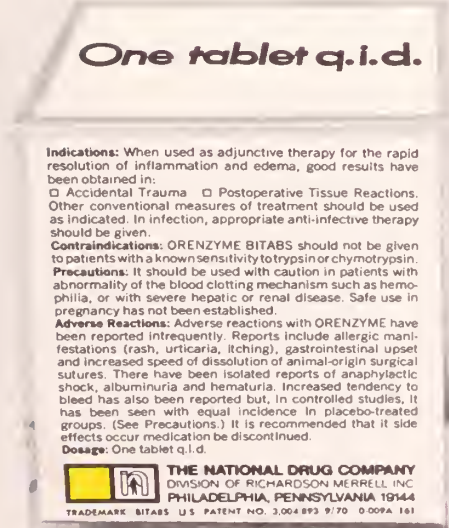
Anesthesia Seminar

Readers of this *Journal* are invited to participate in a graduate seminar in anesthesiology, shaped for the needs of all physicians. The colloquium will be held on March 27 at the Cherry Hill Inn (near Exit 4 of the New Jersey Turnpike), starting at 9 a.m. For details, write to the New Jersey Society of Anesthesiologists, 180 East 21st Street, Paterson 07513.

Course In The Vestibular Apparatus

A part-time, three-day course will be given from 9 a.m. to 5 p.m., Monday and Tuesday, May 3 and 4, and 9 a.m. to noon on Wednesday, May 5, 1971. This course deals with the anatomic and physiologic aspects of vestibular testing and stresses the practical application of these tests. Attention is paid to the evaluation and assessment of test results as part of the audio-logic and otoneurologic workup. The program is given under the direction of Francis M. Fodor, M.D., Director of Otolaryngology at the New York Eye and Ear Infirmary, where the course is given. Tuition is \$100. For registration or more details, write to Post-Graduate Institute, New York Eye and Ear Infirmary, 310 East Fourteenth Street, New York 10003.

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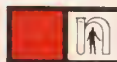
Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

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MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1971

February

- 3 Academy of Medicine of New Jersey
and St. Michael's Medical Center
10 Newark
Cineangiography
- 3, 10, Columbus Hospital
- 17, 24 Hospital Annex, Newark
Simplified ECG for the Family Physician
- 3, 10, Muhlenberg Hospital
- 17, 24 Plainfield
Neurology
- 4 Burlington County Memorial Hospital
Mount Holly
Immunology and Neoplastic Diseases
- 4 Saint Barnabas Medical Center,
Livingston
Hormonal Cytology
- 9 Academy of Medicine of New Jersey
Morristown Memorial Hospital
Morristown
Antibiotics
- 11 Burlington County Memorial Hospital
Mount Holly
Fibrinolysis and Fibrinolytic Agents
- 16 Associated Eye Residencies of New
Jersey
Eye and Ear Infirmary, Newark
Intracranial Meningiomas: Their Ocular Signs
- 16 Academy of Medicine of New Jersey
Englewood Hospital, Englewood
Diagnosis and Treatment of Shock
- 18 Burlington County Memorial Hospital
Mount Holly
Emotional and Psycho-social Maturation
- 24 Academy of Medicine of New Jersey
Albert Einstein Medical Center,
Newark
Pediatric Renal Disease

- 25 Burlington County Memorial Hospital
Mount Holly
Physiology of Puberty and Psycho-sexual Ma-
turation
- 25 Sandoz Medical Lectures
Sandoz Auditorium, Hanover
Ophthalmologic Problems in Family Practice

March

- 2 Hudson County Medical Society
- 2 Academy of Medicine of New Jersey
Section on Dentistry
Academy of Medicine Offices
Bloomfield
Saliva in Reference to Systemic Disease
- 3 Camden County Medical Society
Tavistock Country Club
Haddonfield
- 3, 10, Muhlenberg Hospital
- 17, 24 Plainfield
Neurology
- 3, 10, New Jersey Allergy Society
- 17, 24 Holy Name Hospital, Teaneck
Allergic Dermatitis
- 3, 10, Columbus Hospital
- 17, 24, Hospital Annex, Newark
- 31 Simplified ECG for the Family Physician
- 4 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Drug Addiction
- 4 Burlington County Memorial Hospital
Mount Holly
Management of Infertile Couple
- 4 Academy of Medicine of New Jersey
National Institutes of Health
Bethesda, Maryland
Clinical Infectious Diseases
- 4 Saint Barnabas Medical Center
Livingston
Multiparous Trap
- 4 St. Barnabas Medical Center
- and Livingston
- 5 Gynecological Endoscopy

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|----|--|------------------|--|
| 8 | Academy of Medicine of New Jersey
Paul Kimball Hospital
Lakewood
Drug Addiction | 29 | Cape May County Society |
| 9 | Bergen County Medical Center | 31 | Academy of Medicine of New Jersey
Cornell Medical Center, New York
Heart Surgery |
| 9 | TB-Respiratory Disease Association of
Southern New Jersey | 31 | Academy of Medicine of New Jersey
Hoffmann-LaRoche, Nutley
Symposium—Controversy in Medicine |
| 9 | Middlesex County Medical Society | | |
| 10 | Academy of Medicine of New Jersey
Overlook Hospital, Summit
Respiratory Failure | April | |
| 11 | Burlington County Memorial Hospital
Mount Holly
Sexual Problems Seen in Office Practice | 1 | Burlington County Memorial Hospital
Mount Holly
Pre-diabetic Syndrome |
| 16 | Academy of Medicine of New Jersey
Overlook Hospital, Summit
Renal Failure | 5 | Academy of Medicine of New Jersey
Greenville Hospital, Jersey City
Emergency Room Care |
| 16 | Academy of Medicine of New Jersey
Burlington County Memorial Hospital
Mount Holly
Generation Gap in Medicine | 6 | Hudson County Medical Society |
| 17 | Academy of Medicine of New Jersey
Atlantic City Hospital
Emergency Room Care | 7 | New Jersey Allergy Society
Holy Name Hospital, Teaneck
Allergic Dermatitis |
| 17 | Academy of Medicine of New Jersey
Cornell School of Medicine, New York
Cardiac Drugs | 7 and
14 | Academy of Medicine of New Jersey
Holy Name Hospital, Teaneck
Uremia |
| 18 | Morris County Medical Society | 7, 14,
21, 28 | Columbus Hospital
Hospital Annex, Newark
Simplified ECG for the Family Physician |
| 18 | Gloucester County Medical Society | 8 | Burlington County Memorial Hospital
Mount Holly
Recent Advances in Diabetes Mellitus |
| 18 | Burlington County Memorial Hospital
Mount Holly
Biochemical Parameters of Aging | 8 | Saint Barnabas Medical Center
Livingston
Irradiation Therapy |
| 24 | Academy of Medicine of New Jersey
Dental Section
Veterans Hospital, East Orange
Symposium on Intact Dentition | 13 | Cumberland County Medical Society |
| 24 | Academy of Medicine of New Jersey
Massachusetts General Hospital, Boston
Gastrointestinal Disease | 13 | Bergen County Medical Society |
| 25 | Burlington County Memorial Hospital
Mount Holly
Hyperlipoproteinemias | 13 | Middlesex County Medical Society |
| 25 | Sandoz Medical Lectures
Sandoz Auditorium, Hanover
Problems of Drug Interactions | 14 | TB-Respiratory Disease Association of
Southern New Jersey |
| | | 14 | Academy of Medicine of New Jersey
Runnells Hospital, Berkeley Heights
Difficult Diabetic Patient |
| | | 15 | Gloucester County Medical Society |
| | | 15 | Morris County Medical Society |

- | | |
|---|--|
| <p>15 Burlington County Memorial Hospital
Mount Holly
Management of Exogenous Obesity</p> <p>20 Warren County Medical Society</p> <p>20 Academy of Medicine of New Jersey
Englewood Hospital, Englewood
Leukemia and Lymphoma</p> <p>20 Academy of Medicine of New Jersey
Yale—New Haven Medical Center
New Haven, Connecticut
Endocrinology</p> <p>21 Academy of Medicine of New Jersey
Saint Michael's Medical Center, Newark
Cardiovascular Workshop</p> <p>22 Sandoz Medical Lectures
Sandoz Auditorium, Hanover
The Disturbed Child</p> <p>22 Burlington County Memorial Hospital
Mount Holly
Hypercalcemia</p> <p>28 Academy of Medicine of New Jersey
St. Barnabas Medical Center
Livingston
Pre and Post Operative Care</p> <p>29 Burlington County Memorial Hospital
Mount Holly
Interservice Seminar</p> <p>May</p> <p>4 Academy of Medicine of New Jersey
Morristown Memorial Hospital
Morristown
Diagnosis and Treatment of Shock</p> <p>4 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Drug Addiction</p> <p>5 Camden County Medical Society
Tavistock Country Club
Haddonfield</p> <p>5, 12, Columbus Hospital
19 Hospital Annex, Newark
Simplified ECG for the Family Physician</p> | <p>6 Saint Barnabas Medical Center
Livingston
Familia Toxemia</p> <p>6 Burlington County Memorial Hospital
Mount Holly
Drug Abuse</p> <p>11 Academy of Medicine of New Jersey
Overlook Hospital, Summit
Diagnosis and Treatment of Shock</p> <p>13 Burlington County Memorial Hospital
Mount Holly
Management of Acute Drug Intoxication</p> <p>15 The Medical Society of New Jersey
to Haddon Hall, Atlantic City
18 Annual Meeting</p> <p>20 Burlington County Memorial Hospital
Mount Holly
Amniocentesis and Amnioinfusion in Pregnancy</p> <p>26 Academy of Medicine of New Jersey
Mayfair Farms, West Orange
Annual Awards Dinner</p> <p>27 Burlington County Memorial Hospital
Mount Holly
Breast Cancer</p> <p>June</p> <p>3-4 Saint Barnabas Medical Center
Department of Obstetrics and Gynecology, Livingston
Gynecologic Endoscopy</p> <p>October</p> <p>25-29 Saint Barnabas Medical Center
Department of Obstetrics and Gynecology, Livingston
Obstetric and Gynecologic Pathology</p> <p>December</p> <p>2-3 Saint Barnabas Medical Center
Department of Obstetrics and Gynecology, Livingston
Gynecologic Endoscopy</p> |
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205th ANNUAL MEETING

May 15-18, 1971

Haddon Hall

Atlantic City

OBITUARIES

Dr. A. William Blumberg

Long active in civic affairs in Mercer County, A. William Blumberg, M.D., died on December 18, 1970. He earned his M.D. at the Medical School of Tulane University in 1928. He was a general practitioner, affiliated with the Hamilton Hospital in Trenton, and was 68 years old at the time of his death.

Dr. C. Chester Chianese

One of Mercer County's best-known surgeons, C. Chester Chianese, M.D., died on December 19, 1970 at the age of 74. A past-president of the Mercer County Medical Society, he had had a long tour of duty as secretary of the medical board of the Mercer Hospital in Trenton where, for many years, he had been chief of surgery. A World War I veteran, he was a Fellow of the American College of Surgeons. Dr. Chianese was a 1922 graduate of the Medical School of the University of Pennsylvania.

Dr. Enrique J. Gavilonda

At the untimely age of 45, Enrique J. Gavilonda, M.D., died on November 18, 1970. His illness, which eventually proved fatal, caused him to retire six years ago. At that time he was the pathologist at the Community Memorial Hospital in Toms River. Dr. Gavilonda was a 1950 graduate of the Medical School at the University of Havana, in Cuba. He was a board certified pathologist who served at the Warren Hospital in Phillipsburg before coming to Toms River. Dr. Gavilonda was active in the affairs of our Ocean County Medical Society.

Dr. Raphael R. Goldenberg

One of northern New Jersey's leading orthopedists, Raphael R. Goldenberg, M.D., died on December 15, 1970, at the age of 66.

A 1931 graduate of the Medical School of the University of Toronto, he became active in his chosen specialty early in the 1930s. He was a board diplomate in orthopedics, and served a term as president of the medical board of St. Joseph's Hospital in Paterson. For many years, he was chief of orthopedic surgery at that hospital. At New York University's Medical School, he was an associate professor. During World War II, he saw active duty with the Army of the United States.

Dr. Abraham R. Heller

Forty years of active medical service to the people of Essex and West Hudson came to an end on November 6, 1970, with the death that day of Abraham Heller, M.D. A 1933 graduate of the Medical School of Saint Andrews University in Scotland, Dr. Heller was for almost two decades the Kearny police surgeon. He was on the staff of the Newark Beth Isreal Hospital, and after he moved to Oxford, New Jersey, he became affiliated with the Warren Hospital in Phillipsburg. Dr. Heller was 63 at the time of his death.

Dr. Aaron J. Heisen

A coronary attack on December 24, 1970, suddenly took the life of Aaron J. Heisen, M.D., of Trenton. Born in 1916, he was a 1942 alumnus of the Medical School of the University of Pennsylvania. He was an internist, board certified in internal medicine, active in aerospace medical work, and president of the Mercer Hospital medical staff. Dr. Heisen was a pioneer in the field of methadone treatment of heroin addiction and directed his hospital's clinic in this activity. He served as a captain in the medical corps of the Army of the United States during World War II. He was only 54 years old at the time of his death.

Dr. Andrew E. Ogden

Andrew E. Ogden, M.D., a 1927 Jefferson graduate, came to our state from his native Ohio in 1930. He soon established himself as a surgeon, became a board diplomate in surgery, and was on the staff of the Mercer Hos-

pital in Trenton. He had been the Hamilton Township school physician and was active in the affairs of the American Society of Abdominal Surgeons. Dr. Odgen was 67 years old at the time of his death on December 28, 1970.

Dr. Bartolomeo Rossi

A heart attack on December 6, 1970, took the life of Bartolomeo Rossi, M.D. of Spring Lake. Dr. Rossi received his M.D. at Naples in 1933 and came to the Jersey City Medical Center for his internship. He then moved to Somerville where he practiced for two decades. He was a well-known and prominent figure in that area and served as President of the Somerset County Medical Society. He developed the emergency service at the Somer-

ville Hospital and also had a tour of duty as chief of their outpatient department. He then moved to Spring Lake and did general practice in Monmouth County. He was only 63 at the time of his death.

Dr. John L. Sly

Word has been received from Ridgefield, Connecticut, of the death there, on December 4, 1970, of John L. Sly, M.D., a board certified otolaryngologist who had, for many years, been associated with the Overlook Hospital in Summit. Dr. Sly was born in 1892 and was a member of the class of 1917 of the Cornell Medical School. After retiring to Connecticut, he still retained his membership in our Union County Medical Society.

BOOK REVIEWS

Food Values of Portions Commonly Used, 11th Edition. (Dawes and Church) Revised by Charles F. Church, M.D. and Allen N. Church, B.S., Philadelphia, 1970, Lippincott. Pp. 180. (\$5.40, Spiral Bound)

This book contains a great deal of essential information about the components of patient diets. It is a useful addition to the reference library of doctors responsible for advising patients on details of proper therapeutic diets. The book was first published in 1937 and has undergone eleven editions bringing it up to date. Here, you will find the composition of all commonly used foods. Of special interest, is a listing of the ingredients of 400 food additives in current use in food processing. The authors even include a listing of foods used by our astronauts in the *Gemini* and *Apollo* space flights.

This book is a useful source of reference data on the composition of foods and is recommended as an excellent reference text.

EDWIN KELLERMAN, M.D.

Foetal Autonomy. (Ciba Foundation). Edited by G. E. W. Wolstenholme and Maeve O'Connor. Baltimore, 1970, Williams and Wilkins. Pp. 326. Illustrated. (Price not stated)

The title of this symposium is somewhat misleading since the text does not discuss the control exercised by a mammalian fetus over its own growth and development. It is rather an erudite discussion of basic fetal and maternal physiology gleaned from highly techni-

cal and ingenious work using many different experimental animals.

Adaptation of such observations to man is made all the more difficult by the number of experimental mammals used. The correlation of a complex substance of very high molecular weight (lung surfactant) with the respiratory distress syndrome is of most immediate interest to the clinician.

A chapter on maternal response to fetal antigens is excellent. Preventing graft rejection and even a better understanding of the growth of cancer may lie in solving the mysteries of a maternal-fetal interrelationship. In general, however, this symposium is largely for investigators in the field of embryologic physiology. The obstetrician can benefit by seeing the frontiers of his specialty. Both will find it good for the humility it induces.

GERARD F. HANSEN, M.D.

Handbook of Legal Medicine. Edition 3. Alan R. Moritz, M.D. and R. C. Morris, LL.B. St. Louis, 1970 Mosby. Pp. 238. Illustrated. (\$8.75)

In 1956 the first edition of this book was released, and it has been a successful volume from the start. The current (third) edition brings it up-to-date. It is a concise work-book and not a definitive text. In their quest for brevity, the authors sometimes give a once-over-lightly to material that requires something in depth. For instance, only one and a half pages are devoted to "insanity" which is intended to cover competency, criminal responsibility, commitment procedures, making of wills, and validity of contracts. This very cursory coverage makes this material useless to the reader. The strength of the book lies in the first hundred pages which are devoted to the scientific aspects of medical investigation for legal (mostly criminologic) investigations. The section on malpractice, including some practical hints on prevention, is particularly strong.

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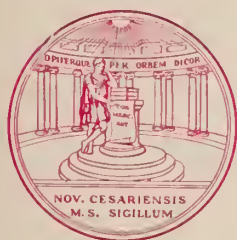
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JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

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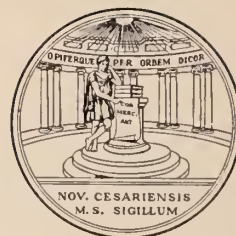
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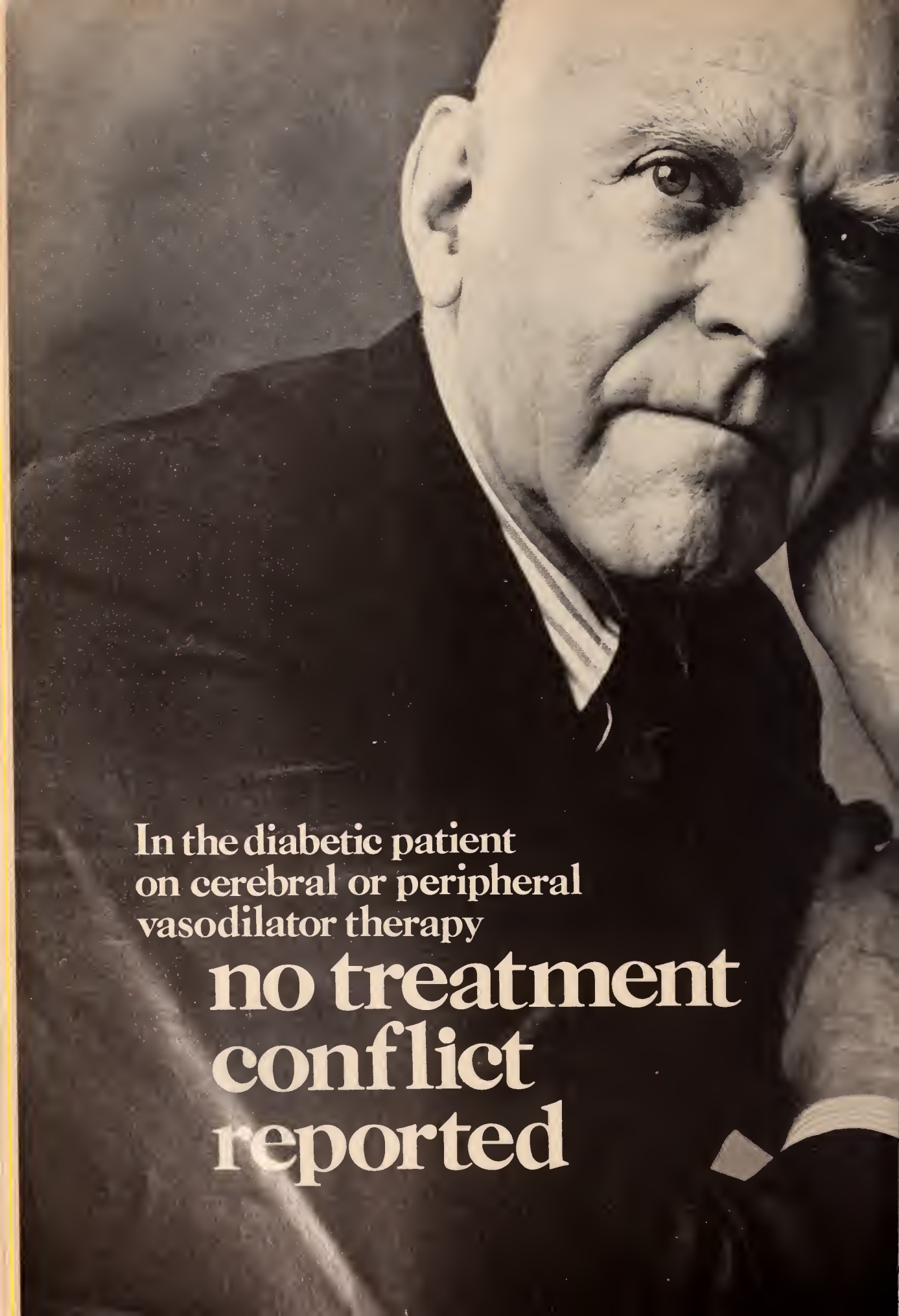


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EDITORIALS

Louis S. Wegryn 1903-1971

A good doctor is also a good citizen. One exemplar of that philosophy has been our prominent Past-President, Louis Stanley Wegryn, who died on February 14. Dr. Wegryn was busy and active in professional, clinical, hospital administrative, and civic affairs through the entire state. He plunged himself into medical society work at all levels. He had been President of the Union County Medical Society and he had served in the Presidential offices of The Medical Society of New Jersey, becoming our one hundred and seventieth President in 1962.

More important to him, however, was his interest in patients. He was involved in whatever was for the benefit of his patients, and in a broader sense whatever benefited his fellow citizens. He was a surgeon at all three hospitals in Elizabeth, his native city, and at Alexian Brothers Hospital he served a term as chief of staff. He was an active member, and finally President, of the American College of Physicians and Surgeons. He was a Fellow of the International Academy of Proctology and eventually became a national director of that Academy. Dr. Wegryn had a long interest in editorial work and contributed many articles to the professional literature. He served on the editorial board of the *American Journal of Proctology*.

These matters took his interest, his time, and his energy. To many of us, the excuse for shirking civic duties is we just don't have enough time. Dr. Wegryn's career reminds us that a busy man can always find time for a cause close to his heart. He has made many unique contributions to the development of The Medical Society of New Jersey and it seems only right that we should pause to pay tribute to that fact.

Dejeuner et Petit Dejeuner

The physician is, or should be, an all-around family adviser on the little health problems as well as the big ones. For instance, is the mid-morning coffee break an adequate substitute for breakfast? The mid-morning break—called “elevenses” in Britain usually occurs about 10 or 10:30 a.m. on this side of the Atlantic. It has become part of the American tradition and is one of the fringe benefits often claimed by labor. The usual justification is that this increases productivity and that, in return for a fifteen-minute break in the morning routine, the employer can look for heightened morale as well as a better yield of work.

There seems to be some evidence that this is a basically sound concept and that when employees stop work about 10 or 10:30 in the morning, they do return to their desks with renewed vigor. However, some people use the mid-morning break as a substitute for breakfast. Or to put it another way, they are getting up later and skipping breakfast. They justify this on the grounds that, after they are at the desk for an hour or so, they will then have coffee and doughnuts or pastry.

The question reduces itself to determining which is better: a normal breakfast or a mid-morning snack? Ordinarily there are more calories in a morning breakfast. Sometimes the breakfast is taken in great haste, whereas the mid-morning break (being on company time) is likely to be in a more relaxed atmosphere. The only experimental study of this was conducted by Doctors Tuttle and Herbert. Productivity was determined by having the subjects do work against a bicycle ergometer. This study (for which there was no lack of volunteers) indicated that the subjects did more work when they had an adequate breakfast *without* a mid-morning snack than they did when they had no breakfast but did take a typical mid-morning break. Insofar as this is a valid study, it appears that breakfast triumphs over the coffee break. The study is perhaps only slightly diluted by the fact that it was financed by the Cereal Institute.

Perhaps it is good for the medical practitioner to know that the only scientific experiment on the subject suggests that if one must choose between an adequate breakfast or a mid-morning break, the breakfast wins hands down.

The Clock Within Us

One of the least understood aspects of human physiology is the poorly understood internal clockwork that paces the rhythm of our daily and annual lives. All nature swings in seasons—the revolution of the earth, the tides of the oceans, the recurrence of the seasons, the cycle of the harvest, even the precession of the equinoxes all speak for a strange periodicity in nature. As part of nature man must share in this cadence. One thinks of the inherent rhythmicity of the heart muscle, the repetitious tide of the menstrual cycle, the ups and downs of body temperatures, the rhythm of tremors, the tidal flow of respiration, and the pulse itself. The ceaseless and repeated alternations of light and darkness must have impressed their rhythm on the earliest of the light-sensing protoplasms, and the ocean tides surely made an imprint on the saline composition of body fluids which came from the saline composition of sea water. Writing in the National Institute of Mental Health's book, *Biological Rhythms in Medicine and Psychiatry*, Bertram S. Brown has pointed out that, "from the moment of conception until death, rhythm is as much a part of our structure as bones and flesh."

Dance is one of the most primitive of early motions—primitive in that it is experienced early in one's life, primitive in that it is part of the cycle of primitive people. The smallest cells of our body participate in a rhythmic tide. Our own fluctuations in mood seem to follow some hidden emotional pacemaker within us, but this has not been meticulously studied.

*In his essay, "The Way to Wealth"


This fascinating field—in a sense a weird field—is reopened by a recent report by the National Institute of Mental Health contained in the book just mentioned. See page 242 of this issue for an informational item on this.

And as Benjamin Franklin* put it, "time is the stuff that life is made of." It is strange that we doctors, the students of man, have not yet dissected the throbbing biologic clock within us.

How To Be Guilty Of Tax Evasion

According to the papers, back in October 1970 a lot of doctors were apparently guilty of under-reporting income from Medicare and other federally funded sources. In speaking to a News Broadcasters' Association, J. E. Breed, M.D. and David Groenninger (from a management consultant firm) explained how this could happen, and in many cases, did happen. Take five physicians in a group practice set-up. In the aggregate they collected, say \$25,000 from these federal sources in the year, averaging \$5000 for each M.D. The federal checks are all made out to Dr. A, who is president or treasurer of the Association, but only \$5000 in fees go to each doctor and these are carefully reported. But, according to the computer, Dr. A got \$25,000 in federal funds and reported only \$5000. So he has "under-reported" \$20,000. Mr. Groenninger said that this kind of operation revealed deficiencies in the I. R. S. or insurance carriers, not deficiencies in the physicians' accounting. Sometimes, the medical director of a private hospital is listed as recipient of all federal funds for that institution, though this may include payment for supplies and medications, as well as fees to 10 or 20 professional people.

The truth eventually does come out. Long after the doctor has been smeared, by innuendo or direct charge.



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ORIGINAL ARTICLES

Skin lesions associated with diabetes are here reviewed and the physiology and pathology of the relationship is discussed.

Skin Lesions In Diabetes Mellitus*

Gabriel Pickar, M.D./Highland Park

There is no skin disease which is exclusive to diabetes but there are a variety of skin lesions, such as necrobiosis lipoidicum diabetorum, and others which occur more frequently in the diabetic than in the non-diabetic patient. Their frequency is related to the diabetic state and should be classified as complications of that disease.

In the untreated or poorly controlled diabetic patient there is an increased susceptibility to skin infection. With improved glucose tolerance this tendency for skin infection is very much reduced. Indeed, it is doubtful whether there is a difference in the susceptibility to skin infection in the adequately treated diabetic. Investigations have been directed toward such obvious changes which occur in the uncontrolled diabetic as continued hyperglycemia, frequent ketoacidosis, and dehydration.

The relation of blood glucose concentration and glucose content of the skin is constant. The average ratio of skin glucose to blood glucose is 55 per cent. As blood glucose levels return to normal, concentrations of glucose in the skin return to normal as well, but more slowly^{1, 2}. Sixty per cent of diabetics with levels of blood sugar between 100 and 200 (true glucose) were strongly positive for glucose on the skin surface as tested with glucose-oxidase test³. This circumstance of

sustained hyperglycemia in and on the skin prompts the explanation that increased sugar content of the skin furthers bacterial growth and results in more frequent infection. Repeated investigations have not supported this obvious and attractive premise. We are now concluding a study⁴ which compares the bacterial count on the skin surface of non-diabetic normoglycemic patients, controlled normoglycemic diabetic patients, and uncontrolled hyperglycemic diabetic patients. To date we have found no difference in the bacterial count in these groups. This suggests that glucose concentrations on the surface of the skin do not promote increased bacterial growth. Hyperglycemia of the skin has not been established as a significant factor in skin infections in the uncontrolled diabetic. But uncontrolled diabetic states interfere with the normal humoral defenses against infection. In patients with ketoacidosis (a not infrequent accompaniment of uncontrolled diabetes) there was found a delay of three to five hours in the granulocytic leucocytic exudate which is the usual response to infection. In ten well controlled diabetic patients there was no such delay noted. More recently Bagdade and his co-workers⁵ demonstrated defective bactericidal activity in the leucocytes of the uncontrolled diabetic. They found that the capacity of these leucocytes to ingest and

* Read before the Joint Session of the Section on Dermatology and the Section on Metabolism, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, New Jersey, May 17, 1970.

kill bacteria was impaired. Insulin restores these leucocytes to more normal function. These investigators suggest that there are circulating factors in the serum of the ketoacidotic patient which impairs bacterial ingestion.

The infections commonly affecting the skin of the diabetic are both fungal and bacterial. Moniliasis and dermatophytosis are the common fungal infections. Furunculosis and other pyodermic lesions usually caused by staphylococci are the most frequent offending bacterial infections. As a rule these infections respond to proper management of the diabetes and suitable antifungal or antibacterial agent.

A common complication responsible for considerable morbidity in diabetes mellitus is degenerative vascular disease. Degeneration of medium and large blood vessels in atherosclerosis is identical in the diabetic and the non-diabetic, but is more likely to occur early and more severely in diabetes mellitus. Blood vessels of the lower limbs are frequently involved. Lesions of the skin related to diabetes occur most commonly in lower limbs. When vascular involvement is severe (which is not uncommon), the ischemia results in specific skin changes. The skin becomes atrophic, it has a smooth and shiny appearance and is often dry due to atrophy of the sweat glands. The toenails are thickened and discolored; the dorsa of the foot and toes are hairless. Vascular occlusion in the terminal blood vessels of the toes leads to gangrene, ulcerations, and infections.

Many capillaries of the diabetic, particularly in the fundus of the eye, the kidney, the skin, muscle, and other structures undergo a distinctive degenerative change. This is characterized by thickening of the basement membrane of the capillary and the deposition in the membrane of a mucopolysaccharide which takes the periodic-acid-Schiff stain. This degeneration of capillaries has been given the general term of diabetic microangiopathy and, when it occurs in the skin, diabetic

dermopathy. These capillary changes occur early in diabetes and may even precede clinical manifestations of altered carbohydrate metabolism or evident disease of the affected structure. This lesion is not unique to diabetes. It is occasionally seen in other diseases. For example, microangiopathy of the fundal vessels of the eye occurs in a variety of anoxic conditions, such as pernicious anemia and leukemia. Dermopathy is not infrequently found in association with severe dermatitis. We do not know whether this degenerative angiopathy is an inherent part of the diabetic syndrome or whether it is related to disturbed carbohydrate metabolism. However, it is a distinctive lesion in diabetes mellitus because it occurs with such great frequency and is related to serious complication in the kidney, the eye, and probably the skin.

Diabetic dermopathy results in narrowing of the capillary lumen allowing less blood-flow to the skin. The thickening of the basement membrane could interfere with exchange of substances from blood to tissue. These factors, if sufficiently severe, could alter normal skin metabolism. I believe this angiopathy contributes to a variety of skin lesions commonly seen in diabetes rather than to a specific skin condition.

I believe that impaired blood supply to the skin (resulting from capillary degenerative changes) alters the integrity of the skin, decreases resistance to trauma, and thus contributes to infection and delayed healing.

Another lesion is comprised of multiple, usually discrete, round or oval, dull red papules measuring from 6 to 12 millimeters. They usually appear in a linear arrangement on the extensor surfaces of the limbs. It is most frequently seen on the lower limbs in diabetic males over the age of 30. It is occasionally seen in the non-diabetic patient. The lesion heals slowly over a period of months and leaves a shallow depression which frequently becomes hyperpigmented. Melin⁴ was the first to report this lesion. He described it as

a. "atrophic circumscribed skin lesion in the lower extremities of diabetics." Others have referred to the lesion as "pretibial pigmented patches." Binkley⁵ has identified this as the principal lesion in diabetic dermopathy. The acute lesion shows epidermal necrosis, degeneration of the collagen, and small vessel changes typical of diabetic microangiopathy. Necrobiosis lipoidica diabetorum (NLD) is a rare complication. It is noted in 0.3 per cent of diabetic patients. Initially this lesion was described as a complication of overt diabetes mellitus. However, it may occur where diabetes is not easily demonstrated or apparently absent. The incidence of diabetes in patients with NLD has been reported as high as 90 per cent and as low as 15 per cent. In a study at the Mayo Clinic⁶ of patients with NLD, 65 per cent had clinical diabetes. The appearance of the lesion is identical in the diabetic and the non-diabetic. It occurs most frequently in the female involving the anterior aspect of the leg. Average age of appearance in the diabetic is 35. In the non-diabetic, it is 42 years. The lesions of NLD are oval, irregular, sharply defined sclerotic plaques which are yellow in the center, violaceous at the periphery. The center of the plaque becomes atrophic and telangiectases can be seen. In approximately 30 per cent of cases these plaques ulcerate leaving painful, slowly healing ulcers. Recent histopathological studies reported by Muller and Winkelmann⁶ reveal that in patients having diabetes mellitus there is extensive necrobiosis and considerable amounts of extracellular lipid with relatively little epithelioid cell response. In patients without clinical diabetes a similar lesion is noted except there is predominantly a tuberculoid appearance. The significance of this difference is not understood but could reflect a relative susceptibility of the individual with little epithelioid cell response to the development of overt clinical diabetes.

Focal degeneration of the collagen is the primary event in NLD, a circumstance which is seen in a variety of non-diabetic skin diseases such as granuloma annulare and rheumatoid nodules. I believe that in NLD diabetic der-

mopathy is an important etiological factor.

Diabetic neuropathy is one of the commonest complications of diabetes. In severe chronic sensory neuropathy (the commonest form of this complication) there may be trophic changes to the feet and ankles. Sensory denervation is responsible for loss of pain sensation and clinical expression is not unlike other chronic sensory denervating diseases such as tabes and syringomyelia. The skin of the sole of the feet becomes dried, fissured and hyperkeratotic. Thick callosities form over pressure points. Acute ulcerations resulting from unrealized burns and trauma are a complication of the loss of sensation. Traumatic ulcerations occur over pressure points such as on the ball of the foot, in association with hallux valgus, on the heel and between the toes. Ill-fitting shoes are a common source of trauma. Not uncommonly, the ulceration is preceded by a callus which becomes infected. The relation of pressure to ulcer formation in desensitized skin is well demonstrated in the Charcot joint of the foot where collapsed joints create oddly placed pressure points and ulcer formation. The effects of neuropathy on the skin are undoubtedly enhanced by ischemia.

Severe *hyperlipidemia* may complicate poorly controlled diabetes and severe ketoacidosis. Under these circumstances you may see an acute secondary xanthomatous eruption. The lesion appears as a widespread symmetrical crop of discrete papules and nodules usually involving the extensor surfaces of the limbs, the elbows, the knees, and the buttocks. The lesions are small, pinhead to pea-size, with an inflammatory areola about the base. The papules are usually soft (but may be firm) and the apex is yellow resembling pustules in appearance. Proper treatment of the diabetes reduces the lipidemia to normal levels and the eruption disappears. Histologically the lesion shows aggregates of lipid-filled histiocytes in the dermis with an inflammatory infiltrate of lymphocytes. It has been suggested that the fundamental cause of this eruption is a disturbance of lipid rather than carbohydrate

metabolism and that we are dealing with an acute dermal response to hyperlipidemia. For this reason the name xanthoma eruptivum rather than xanthoma diabeticorum has been recommended. This xanthoma should be distinguished from the chronic tuberous and tendinous xanthomas seen in diabetes associated with longstanding hyperlipidemia.

Carotinosi is a yellowish discoloration of the skin due to binding of carotene, a yellow pigment in the skin. The yellow discoloration is most evident on the palms and soles but is also seen on the rims of the nostrils and ears, the nasa-labial folds, and over bony prominences. Increased amounts of carotene are not uncommon in the serum of diabetic patients but only occasionally is this sufficient to cause yellowing of the skin. Increased amounts of carotene in the diabetic might be due to increased ingestion of carotene-containing foods such as carrots or squash, or possibly to impaired conversion of carotene to vitamin A. This is a harmless condition frequently improved with a diet low in carotinoids.

Generalized *allergic reaction* to insulin is rare. Frequently there is a history of previous insulin therapy which is interrupted for a trial on diet or oral antidiabetic agents. The reaction occurs shortly after insulin has been resumed. Following local irritation and redness at the site of insulin injection there is a generalized urticarial rash, swelling of the eyelids and face, malaise, and joint pains. Therapy is the same as for any generalized allergic reaction.

Local reactions to insulin are more frequent. The most common of these reactions is *lipodystrophy*. This is a localized atrophy of subcutaneous fat at the site of repeated insulin injections. The result is a depression in the skin varying in size from a few centimeters to a few inches. Rarely, it has been reported occurring after only a few injections of insulin and has appeared in areas removed from the site of injection. This reaction occurs most frequently in women and children of both sexes. It is rare in males but has been

reported in diabetic males with advanced liver disease and gynecomastia suggesting that androgens normally may be a protective factor. This seems to be directly related to the effects of injections of insulin.

Local sensitivity is another common reaction to insulin which usually occurs about two weeks after insulin therapy has been started.

A red indurated area, which lasts for two to three weeks and disappears, is visible at the site of injection. Skin sensitivity to insulin is managed by either changing the type of insulin or undertaking a program of insulin desensitization.

Improper administration of insulin into the skin rather than subcutaneously produces a disturbing lesion which passes through stages of induration, necrosis, ulceration, and scarring. The final lesion resembles the pitting and scarring of smallpox.

Insulin "tumors" are infrequent. They are seen most often in children as a result of repeated injection into the same area. It occurs in children because the overlying skin becomes insensitive to the needle and the child prefers to avoid the sensation of needle prick. These lesions may be prevented by avoiding repeated injections to the same area. If necessary, these masses may be removed surgically.

Sulfonylurea compounds and the biguanide derivatives have produced few reactions affecting the skin. Urticaria, morbiliform and maculo-papular eruptions, purpura, erythema multiforme, and exfoliative dermatitis have been reported. As a rule, these lesions improve quickly when the drug is stopped. In patients taking sulfonylurea drugs, an unusual reaction may occur after ingesting ethyl alcohol. Within ten minutes after drinking the alcohol, there appears flushing of the face and injection of the conjunctiva. The reaction is harmless and usually lasts an hour, occasionally longer. This reaction can be prevented by taking antihistamine drugs one

hour before drinking alcohol.

There are a number of diseases with cutaneous manifestations in which there is an increased incidence of diabetes mellitus. It is not within the scope of this presentation to discuss these diseases but they are worthy of mention; they are porphyria cutanea tarda, hemochromatosis, Weber's syndrome, lipoid proteinosis, lipodystrophy syndrome of Seip-Lawrence.

205 North Second Avenue

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National Ambulatory Medical Care Survey

The National Center for Health Statistics in the Department of Health, Education, and Welfare is planning the National Ambulatory Medical Care Survey (NAMCS). This information is needed for planning and organizing health services, for planning efficient utilization of health facilities and manpower, and for determining modifications in medical education.

The survey will involve a sample of physicians who will be requested to provide data concerning a small number of the ambulatory patients they see. When the NAMCS is in full operation (sometime in 1972) about 3,000 physicians each year will be providing data on an estimated 240,000 ambulatory patient visits. Physicians selected to participate will provide information concerning a sample of the patients that they see during a two-day period. All physicians will be replaced by new sample physicians after participating for four quarters. The types of data the survey will collect include age, sex, and medical problems of patients, plus treatment prescribed and laboratory tests performed for patients. All data will be held completely con-

fidential and used only for statistical purposes.

Ambulatory medical care is the largest segment of the American health services system in terms of prevalence and volume. The dearth of information on this subject has led leaders in the medical profession to persuade the National Center for Health Statistics to undertake the National Ambulatory Medical Care Survey. This information will complement health data already being obtained by the Center. The success of the NAMCS will depend on the cooperation of practicing physicians who are the major source of ambulatory medical care data.

The American Medical Association and other major medical associations have expressed support for the NAMCS and have provided advice and consultation in its development. With the cooperation of practicing physicians, the survey will provide very valuable data for documenting the health status of the American people and for informing public and private policy decisions.

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*Slanger, A.: Med. Times 94:150 (Feb.) 1966.

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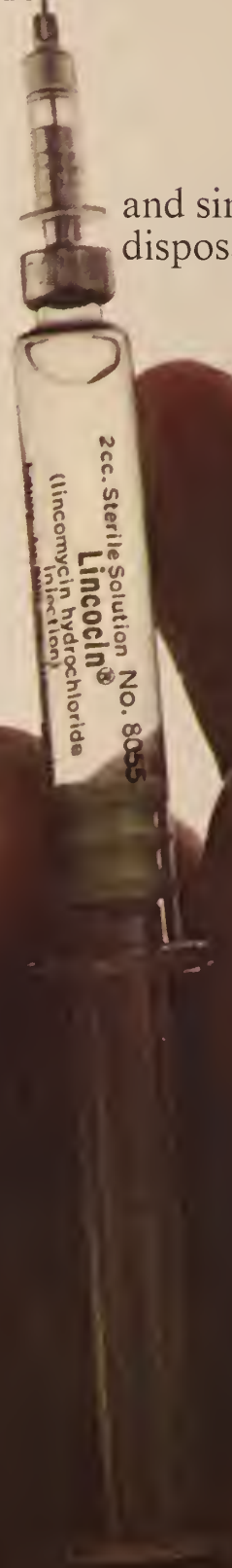
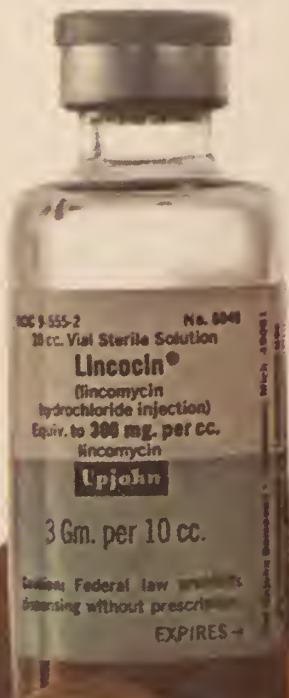
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Dosage and Administration: One or two tablets daily, as indicated by clinical need.

How Supplied: Orange-colored, capsule-shaped tablets, imprinted Roche 73; bottles of 100.

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With some provisos here specified, Dr. Browdy answers "no" to the query: Is the automatic, routine Coombs test really necessary? But the blood cord routine should be continued with Rh negative mothers.

Fate Of Coombs-Positive Newborns

Is Routine Or Selective Cord Coombs Testing Really Worthwhile?

Sol Browdy, M.D./Trenton

Ten years ago it was decided at Mercer Hospital to make a deliberate attempt to identify at birth those infants who were most likely to be affected by hemolytic disease of the newborn. A cord blood routine was instituted whereby samples of clotted and oxalated umbilical cord blood were collected at the time of delivery of every mother who was Rh negative or belonged to group O or both (except when the father was also known to be Rh negative or type O). Group O mothers were selected because they are involved in over 95 per cent of cases of ABO hemolytic newborn disease. According to the Rh negative protocol, if the infant proved to be Rh negative, no further tests were done. If the infant typed Rh positive, a Coombs test was performed. If the Coombs test was negative, no further testing was followed. If the Coombs test was positive, a cord bilirubin and CBC were performed

With the type O mother, if the infant also proved to be type O, no other tests were scheduled. When the cord blood routine was originally established, it was felt that a negative Coombs test by what we considered to be our relatively insensitive technic did not preclude ABO hemolytic disease, so that if the infant typed as A or B, then all three determinations were made—Coombs test, bilirubin and CBC. Subsequent experience has disproved this assumption and we now insist on a positive Coombs test, strong or weak, in

making the diagnosis of *all* newborn hemolytic disease, Rh and ABO. Conversely, a positive cord Coombs test indicates red blood cell sensitization, clinical or subclinical, until proved otherwise.

It was decided to review the fate of the Coombs positive newborn during his stay in the nursery. The year 1968 was selected because it was the year before the introduction of two obstetrical-pediatric practices which will ultimately alter the incidence of Rh hemolytic disease and reduce the need for exchange transfusion in mild ABO hemolytic disease as well as cases of non-hemolytic hyperbilirubinemia. The first innovation was the commercial availability and use of hyperimmune Rh gamma globulin in unsensitized Rh negative mothers; the second was the installation of phototherapeutic units in our newborn nurseries.

During 1968 in-hospital births totalled 1759. Some 1300 cord blood specimens were studied because of potential Rh or ABO incompatibility. This number also includes a small number of cases where the blood type of the mother was not known primarily because of lack of prenatal care. The number of cases of actually incompatible mother and infant blood types amounted to 329 or 17 per cent of all births. Of the 329, 105 or 32 per cent resulted in Coombs positive infants; 224 (68 per cent) were Coombs negative. In other words, 8 per cent of the potentially incompatible matings resulted in Coombs positive

Incompatibility	: O-A ₁ :	Rh neg-Rh pos :	O-B :	O-A ₂ :	O Rh neg-A ₁ pos :	O Rh neg-A ₂ Rh pos :	Total
Hemolytic disease	: 9 :	5 :	3 :	5 :	1 :	0 :	23
Required exchange	: 3 :	2*	: 1 :	0 :	0 :	0 :	6
Subclinical disease	: 26 :	2 :	24 :	27 :	2 :	1 :	82
Total	: 35 :	7 :	27 :	32 :	3 :	1 :	105

* One case of fetal hydrops expired before exchange transfusion could be performed.

infants. An analysis of the Coombs positive cases is presented above.

The majority of Coombs positive infants, 82 per cent, were not clinically affected. In our terminology, clinical hemolytic newborn disease means early onset of jaundice in a Coombs positive infant, specifically within the first thirty-six hours of life, regardless of the depth of jaundice or level of serum bilirubin attained, with or without hepatosplenomegaly, anemia, hemorrhagic, or neurologic manifestations. Jaundice developing after 48 hours of life is rarely due to hemolytic disease and according to most authorities a maximal serum bilirubin level of 15 milligrams per cent is to be considered "physiologic." Hence, "subclinical (or latent) disease" is reserved for those Coombs positive infants of Rh or ABO incompatible matings in whom jaundice does not appear before the first 48 hours of life and bilirubin levels do not exceed 15 milligrams per cent.

Over half of the subclinical cases involved a type O mother and type A father (equally divided among subgroups A1 and A2). Thirty per cent of the cases resulted from O-B matings. Analysis of the cord bilirubin levels of the subclinical cases revealed that all were below 3.5 milligrams per cent; the majority were under 2.0 milligrams per cent; only one case exceeded 3 milligrams per cent.

A break-down of the six cases of hemolytic disease requiring exchange transfusion is listed below.

Thus, four of the six clinically affected infants requiring exchange transfusion started out with cord bilirubin levels above 3.5 milligrams per cent. And among fifteen affected infants who did not require exchange all but two had cord bilirubin levels below 3.5 milligrams per cent. Expressed statistically, in this series of cases, the probability of any Coombs positive infant with a cord bilirubin level above 3.5 milligrams per cent requiring exchange was 67 per cent; below 3.5 milligrams per cent the expectancy was 13 per cent. These figures compare closely with those of Wheeler and Ambuel,¹ who showed that when the cord bilirubin exceeded 4 milligrams per cent, 80 per cent of the infants eventually required exchange; when less than 4 milligrams per cent, 20 per cent subsequently required exchange. We consider cord blood anemia, erythroblastemia and reticulocytosis less reliable prognosticators for ultimate exchange transfusion.

During 1968 there also occurred two cases of hr' (c) hemolytic disease, one of which required exchange transfusion. In addition six Coombs negative infants came to exchange transfusion because of non-hemolytic hyper-bilirubinemia. These included one case of aspiration pneumonitis, one case of prematurity and two cases of prematurity and associated respiratory distress syndrome. In two cases the cause was obscure.

In their three year search of 20,334 pregnancies for ABO hemolytic disease Krafft and Haberman² found that only 95 infants or 2.4

	: Rh neg-Rh pos :			O-A ₁		O-B	
Incompatibility	: Case	: Case	: Case	: Case	: Case	:	
	#1	#2	#1	#2	#3	:	
Gravida	: 2	: 3	: 7	: 3	: 1	:	5
Cord bilirubin, mg %	: 7.2	: 11.5	: 3.8	: 2.9	: 2.2	:	3.6
Cord hemoglobin, gm%	: 14	: 11.8	: 12.9	: 11.5	: 15.2	:	9.6
Cord nuc. RBC's/100 WBC	: 17	: 59	: 7	: ?	: 5	:	?
No. exchanges	: 1	: 3	: 1	: 2	: 1	:	1

per cent of the 3,921 potential incompatibles were clinically affected. Two hundred twenty-eight or 70 per cent of the number who demonstrated serologic evidence of ABO isoimmunization by both Coombs and heat elution tests showed no clinical disease and were designated cases of latent isoimmunization. Despite their findings of relatively high frequency of subclinical cases, they recommend routine cord Coombs testing of all newborns.

Zuelzer and Kaplan³ were of the opinion that in A x O incompatible matings only subgroup A₁ infants are affected, although by our criteria we encountered five mildly affected A₂ infants in our series. Based on their work, Levine⁴ recommended limitation of search for ABO hemolytic disease to all group O pregnant women whose husbands belonged to group A₁, B and A₁B. Matings A₂B x O were to be included because this mating is incompatible for the B factor.

After ten years' experience with our own cord blood routine, one may ask, Is it really necessary or worthwhile? Do the hoped for advantages of early identification outweigh the disadvantages of over-burdening a laboratory staff and nurses and taxing the patient financially? Actually it can be argued that the early identification of 82 Coombs positive subclinical cases served no useful purpose. The positive Coombs test report in these cases was of nuisance value because the alarmed nursery nurse personnel usually promptly notified the attending physician of the report, regardless of the time of day or his whereabouts. Of course, neither the pediatrician nor the nurses knew that in these 82 cases the clinical picture of hemolytic disease would never develop. But all parties concerned kept their eyes glued for the first sign of jaundice, and the physician felt obliged to inform his patient of the potential problem. The point remains that if the cord blood examinations had *not* been performed in this group, no one would have been the wiser and the infants would have passed through an uneventful neonatal course unscathed.

Practically speaking, the study of the 1300

cord blood specimens in our series yielded 23 cases of hemolytic disease, 6 of whom were sufficiently affected to require exchange transfusion. The usual hospital laboratory charge for a blood typing—major blood group, Rh and hr'—is \$5. Cost of a Coombs test is also \$5. Thus, from a financial standpoint, if instead of initially typing the infant, a Coombs test had been performed, the number of "profitable" typings could have been reduced to 105, resulting in an overall net savings of \$1120.

1300 typings @ \$5	=	\$6500
329 Coombs tests @ \$5	=	1645
		<hr/> \$8145

1300 Coombs tests @ \$5	=	\$6500
105 typings @ \$5	=	525
		<hr/> \$7025

How valuable was the cord blood routine in the management of the 23 clinically affected infants? Restated, what if there had been no cord blood examinations? All 23 infants would have come to study by the second day of life by virtue of early jaundice. Of the six exchanged cases, four had cord bilirubin levels above 3.5 milligrams per cent, which immediately alerted the physician to probable need for early exchange transfusion. In the two Rh incompatibility cases the cord bilirubin levels were 7.2 and 11.5 and both infants were exchanged shortly after birth. On the other hand, in two of the four ABO cases the cord blood bilirubin levels of 2.2 and 2.9 did not particularly disturb the physician. Yet the case with 2.9 milligrams per cent required two exchange transfusions to control the hyperbilirubinemia. Paradoxically, the case of Rh incompatibility with cord bilirubin of 7.2 milligrams per cent required only one exchange (probably due to the earlier timing of the transfusion).

If attention is focused only on the seven Rh incompatibility Coombs positive infants—three others were "protected" by concurrent ABO incompatibility—five of them were clinically affected, compared to only seventeen of

ninety-four ABO incompatible Coombs positive cases. It appears to me that we have been spending time and money unwisely and experiencing unwarranted anxiety in searching for potentially affected ABO cases of hemolytic disease with our cord blood routine. However, we should continue with our time-honored Rh negative cord routine by performing a screening Coombs test. If positive, then bilirubin and blood count determinations should be performed. Obstetricians will take over when the Coombs test is negative and the infant is Rh positive by offering their mothers hyperimmune Rh gamma globulin.

For the benefit of those physicians who feel that they may be missing a significant number of cases of neonatal hemolytic disease by not routinely Coombs testing all newborns, the study by Krafft and Haberman² provides relevant data with respect to ABO hemolytic disease. Their series of 3921 heterospecific pregnancies included not only 2947 cases of group O mothers but also 974 cases of other combinations involving group A mothers with B infants; group A mothers with AB infants; B mothers with A infants; and B mothers with AB infants. Yet of the total of 95 clinically affected infants in the entire series only two of the mothers did not belong to group O (mother B, infant A).

Conclusion

Approximately 1300 cord blood specimens selected for potential blood group incompatibility were studied in a deliberate attempt to identify at birth those infants who were most likely to be affected by Rh or ABO hemolytic disease. Only 23 of 105 Coombs positive infants were clinically affected, 6 of whom required exchange transfusion. Since only 17 of 94 ABO incompatible newborns were clinically affected and since elimination of the information gleaned from the cord blood ex-

aminations would not have jeopardized the management of the 4 ABO cases which were treated by exchange transfusion, it is felt that the routine cord blood study of the type O mother should be abandoned. It is also felt that routine cord Coombs testing of all newborns would be a waste of time and money.


However, the Rh negative mother cord routine should be continued, not only because the yield is more fruitful but because the height of the bilirubin level may materially influence the timing of the therapy and secondarily the obstetrician requires knowledge of the infant's Rh type and Coombs test in selecting those mothers who will benefit from hyperimmune Rh gamma globulin. Parenthetically, obstetricians should be aware of the fact that when the mother is type O Rh negative and the infant is either A Rh positive or B Rh positive, the Coombs test may be weakly positive (on the basis of ABO incompatibility) and if no Rh antibodies can be demonstrated in the mother, she is a candidate for Rh gamma globulin. Finally, it bears repetition that the Rh typing of the Coombs positive neonate should not be irrevocably accepted because many type as negative by virtue of the blocking (albumin) antibody. There still is no substitute for accurate, repeated clinical observations and a healthy index of suspicion.

I wish to acknowledge the able assistance of Mrs. Barbara Sharpley of the Blood Bank and Miss Florence Davis and Mrs. Barbara Heenan of the Medical Records Department in the preparation of this manuscript.

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Before Administration of Loridine

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2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

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1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



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Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

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ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

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This is one of the very few (perhaps the only) leiomyosarcoma of the gallbladder reported from New Jersey.

Leiomyosarcoma Of The Gallbladder*

**Harry M. Friedland, M.D., et al.
Newark**

Leiomyosarcoma of the gallbladder is exceedingly rare. Of seventy-two sarcomas of the gallbladder collected from the world literature by Riganti and Mieres,¹ only eight were classified as leiomyosarcomas. Three additional cases have been reported since then.^{2, 3, 4} Della-Valle⁵ found only thirty-nine malignancies of the gallbladder among 23,665 autopsies. Only three were sarcoma.

Seventy-five per cent of all cases of sarcoma of the gallbladder have occurred in women, with a maximum incidence in the sixth decade. Cholelithiasis is present in eighty per cent of the cases.⁶

It is difficult to make the clinical diagnosis of sarcoma of the gallbladder. Often there is a history of preceding symptoms suggestive of cholelithiasis. Superimposed upon this is the appearance of a hard mass in the right upper quadrant associated with pain and weight loss. Frequently the sarcoma attains a very large size. On oral cholecystography the gallbladder does not usually visualize. However, it may attain sufficient size to exert pressure on the stomach or duodenum and be recognized as "a large gallbladder tumor" in a barium meal. Carcinoma does not usually cause as much enlargement of the gallbladder.⁶

The tumor grows quickly and usually spreads to neighboring structures, or to distant organs. The course is rapid with death usually occurring within one year of the time of diagnosis.

An eighty-six year old woman was admitted to the Presbyterian Hospital with a two week history of non-radiating right upper quadrant pain unrelated to food intake. She had noted progressive weight loss, dark urine, and a yellowish discoloration of the skin. The gallbladder had not been visualized at an oral cholecystogram done one year before admission for evaluation of abdominal pain.

She was a well developed, well nourished female in no acute distress. Blood pressure was 130/88. The skin and sclerae were icteric. There was a round, tender mass in the right upper quadrant. The liver was slightly enlarged; the spleen was not palpable. Hemoglobin, white blood count, differential, sedimentation rate, urinalysis, and blood urea nitrogen were within normal limits. The direct acting bilirubin was 4.7 and the total bilirubin 9.4. Serum glutamic pyruvic transaminase (SGPT) was 94 units, serum glutamic oxaloacetic transaminase was 193 units, alkaline phosphatase 25.6 S.I.R. units, cholesterol 337, prothrombin time 15/13 seconds, and fasting blood sugar 176. A flat film of the abdomen was unremarkable.

At the time of surgery the gallbladder was found to be very hard and distended with multiple stones. The cystic and common ducts were dilated and contained numerous calculi. The remainder of the abdominal examination by the surgeon was essentially normal. Routine cholecystectomy was done.

Microscopic sections of the gallbladder wall showed an unexpected tumor (Figure 1) in addition to acute and chronic inflammation. The constituent tumor cells were large, bizarre and spindly and frequently giantiform, and appeared to have arisen in the gallbladder muscularis where they had spread to overgrow and replace the mucosa of the body, while sparing the gallbladder neck and attached segment of cystic duct. In some areas they produced a quite well-defined whorled pattern (Figure 2) but in general the picture was of extreme disorganization. Intravascular growth of the neoplastic cells was not present. Tumor necrosis and hemorrhage were prominent features.

The patient was readmitted ten months later because of the recurrence of abdominal pain. A rocky-hard, irregular, freely movable mass about ten centimeters in diameter was present in the right upper quadrant. A liver scan was suggestive of infiltration in the lower portion of the liver by tumor. She was treated with cobalt radiation (6,000 rads) with diminution in size

* From the United Hospitals of Newark (New Jersey), where Dr. Friedland is Assistant in Medicine and Gastroenterology. The co-authors are Dr. Homer D. Schaaf, who is attending in Pathology, and Dr. Saul O. Sobol, who is attending in Medicine.

of the mass and relief of pain. She died five months later.

At autopsy a tumor mass was found in the liver about the gallbladder bed, extensively infiltrating in and about the thickened junction of the common hepatic and common bile ducts, the proximal duodenum, the pylorus and antrum of the stomach, and hepatic flexure of the colon. Considerable tumor necrosis, especially in the liver mass, was present.



Figure 1—Section through gallbladder wall showing tumor arising from muscularis (100x)

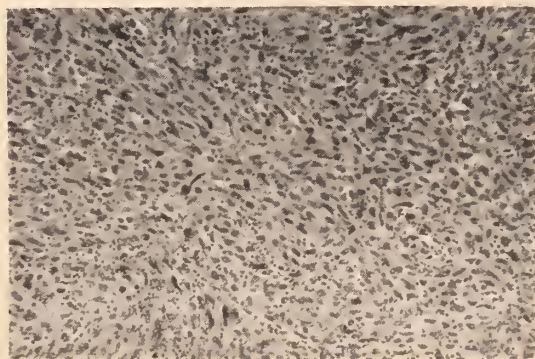


Figure 2—Section of tumor showing whorled, spindly pattern (450x)

The clinical picture presented by this patient is fairly typical of sarcoma of the gallbladder except for the relatively small size of the tumor at the time of exploration. No evidence of malignancy or metastasis was present at surgery. The tumor was first discovered when

the histologic sections were examined. The patient's symptoms were undoubtedly caused by the stones in the cystic and common bile ducts.

Histologically, sarcoma of the gallbladder can exist in undifferentiated or differentiated cell forms. The undifferentiated form is more common, occurring in about seventy per cent of the reported cases. Frequently it is difficult to distinguish between undifferentiated sarcomas and spindle cell carcinomas. Tumors recognized as being of muscle origin are the more frequent form of differentiated sarcoma, with eleven cases of leiomyosarcoma of the gallbladder reported in the world literature.

The better differentiated areas of tumor in this patient resemble that seen in an ordinary cellular uterine leiomyoma. Tissue of muscle origin is readily apparent with the Masson trichrome stain.

Edmondson⁷ has described a rhabdomyosarcoma of the gallbladder that contained areas of eosinophilic cytoplasm with cross striations. No cross striations are found in this present case despite extensive sectioning and the use of PTAH and iron hematoxylin stains.

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Here is an unusual, often misdiagnosed syndrome needing cooperation among the dermatologist, the neurologist, the dentist, the pathologist, and the radiologist.

Basal Cell Nevus Syndrome*

A Report Of Two Cases And A Review Of The Literature

Richard A. Hurwitz, M.D./Jersey City

The basal cell nevus syndrome is a triad of defects that include multiple basal cell nevi, skeletal malformations and mandibular cysts. These individuals possess changes in the central nervous system, soft tissues, ocular region, cutaneous, osseous, and facial areas of the body. Earliest manifestations of the syndrome may be in the detection of single or multiple basal cell nevi scattered throughout the body especially on the face or about the eyes, nose, and cheeks. At times these basal cell nevi may be the last distinct entity to be determined clinically while the other systems have previously demonstrated changes compatible with the entire basal cell nevus syndrome.

The two cases below described are to be now added to the literature. In one a unique and previously unreported calcifying non-odontogenic myxoma was found at surgery.

Case 1

The patient is a 19 year-old male referred to the dental service with a feeling of pressure on the right side of the face associated with a foul taste in the mouth. In the dental clinic radiographs were obtained and a mandibular right impacted third molar tooth was noted. This was associated with a dentigerous cyst. X-rays also revealed a dense opacification of the left antrum associated with definite enlargement and expansion of this structure.

Prior to his entry into the military service, a large dentigerous cyst was surgically removed by an oral surgeon from the right mandibular ascending ramus. The pathologist reported this as an inflamed follicular cyst associated with a mandibular right second molar tooth. A few months later another cystic lesion was surgically removed from the left ascending mandibular ramus with an impacted mandibular left third molar tooth. Here the pathologist reported a severely inflamed follicular cyst associated with an impacted mandibular left third molar. A few years later, while

in the armed services, a mandibular right impacted third molar tooth which was associated with a dentigerous cyst and a maxillary right third molar tooth, was surgically removed. The mandibular operative site healed uneventfully, but the patient experienced mucopurulent discharge from the maxillary operative site. It was concluded that he had a draining oro-antral fistula of the right posterior maxilla which was associated with a large dentigerous cyst which was occupying the entire right antrum.

Shortly after this, examination revealed a well developed, well nourished 19 year-old caucasian male in no acute distress. He had a marked *pectus excavatum*. There was a slight facial asymmetry on the left side. Intra-oral examination demonstrated a draining oro-antral fistulous tract in the right posterior maxillary tuberosity area. Intra-oral palpation of the left side revealed a marked expansion of the left lateral antral wall.

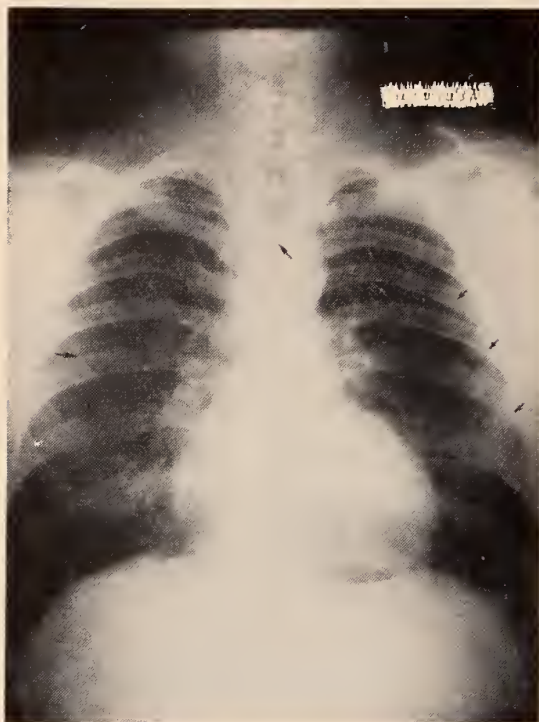
Chest x-ray confirmed marked *pectus excavatum*. Multiple bifid ribs were also demonstrated and a spina bifida involving the upper thoracic vertebral column was present. The Water's view and laminagrams of the antral regions disclosed a markedly expanded densely opacified left maxillary antrum. The right antrum was replaced by a cystic lesion associated with an impacted molar tooth which had been displaced upward to the floor of the right orbit. Skull films showed calcification of the petro-clinoid ligament. He had several small elevated growths on the face, which included both pigmented and unpigmented. Punch biopsy of the lesions on the face were reported as indicating basal cell carcinoma.

A Cauldwell-Luc procedure was performed on the patient's left antrum and a calcifying non-odontogenic myxoma was surgically removed, along with the impacted maxillary left third molar. This calcifying non-odontogenic myxoma is a relatively innocuous lesion without the usual infiltrating potential of a true myxoma.

A Cauldwell-Luc procedure was done on the right antrum and a large dentigerous cyst was enucleated. The associated maxillary right second molar was removed. Following this procedure the patient had repeated episodes of facial swelling with mucopurulent discharge. A second Cauldwell-Luc procedure was performed on the left maxillary sinus. On this occasion purulent granulation tissue was removed from this area. The patient had daily sinus irrigations which resulted in a gradual but definite clearing of the sinus.

Diagnosis was basal cell nevus syndrome.

*From the Department of Radiology, Christ Hospital, Jersey City, New Jersey.



Case I, Figure 1



Case I, Figure 2

This 19 year-old recruit demonstrated changes of basal cell nevus syndrome. On the chest x-ray multiple bifid ribs and rib anomalies were present. The bifid ribs are arrowed. A central arrow depicts a spinal bifida occulta which is in the upper thoracic region. Lateral chest x-ray with the arrow, points to a prominent *pectus excavatum*.



Case I, Figure 3

A lateral tomogram through the right antral region. The arrow indicates the tooth which is in the dentigerous cyst present in the antrum on the right side.



Case I, Figure 4

The AP laminogram in the Water's facial position demonstrates the changes in the antral regions bilaterally. The tooth in the dentigerous cyst in the right maxillary region is arrowed. The heavy calcified mass lesion with the expansion of the left antrum is noted on this view. The left antral lesion was a calcified non-odontogenic myxoma.



Case I, Figure 5

A lateral laminogram of the left antrum shows the expansion of the antral wall posteriorly. The wall is thin and eggshell-like in structure. The heavy calcified components of the tumor in the antrum are easily identified.

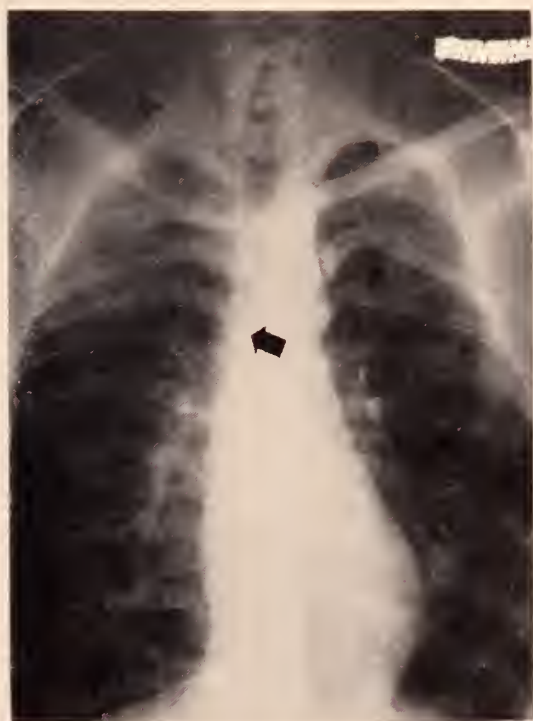
Case 2

This is a 19 year-old male army private admitted for extraction of remaining maxillary teeth and carious teeth of the mandible. The patient had a past history of neglect of the dentition with poor oral hygiene. This was confirmed by examination of the oral cavity, which disclosed multiple carious teeth of both mandible and maxilla. The right maxillary permanent cuspid and the left mandibular permanent cuspid teeth were absent. The deciduous cuspids were still present. The young man had a relatively large head, with a complete bridging of the eyebrows across the midline with hair. Examination of the chest revealed a *pectus excavatum*. Multiple nevi were seen on the face.

Chest x-rays indicated a *pectus excavatum* with multiple rib anomalies. Multiple cystic areas were present within the mandible, as seen on mandibular films. Associated impacted teeth were also noted.

After a review of the chest and jaw radiographs, the patient was evaluated for a basal cell nevus syndrome. Initial dermatologic consultation did *not* reveal any basal cell carcinomas. A second consultation was obtained after prodding by the radiology and dental service. At this time two small basal cell carcinomas were removed from the dorsum of the patient in the thoracic region.

At surgery, cysts and associated impacted teeth were removed. The cysts were subsequently diagnosed as keratocysts. In the cystic areas a thick creamy keratin material was removed. All of the cystic regions con-



Case II, Figure 1

Multiple bifid ribs are present on the chest examination study. The scapulae maintain a high position and at will could clinically be dislocated. A lateral chest x-ray not herein demonstrated also depicted a distinct and prominent *pectus excavatum*.



Case II, Figure 2

A lateral skull examination. The arrow points to petrous clinoid ligament calcification. Note the peculiar structure to the calvarium which indicates at one time that there was premature closure of the cranial sutures.



Case II, Figure 3

Several lucent regions in the mandible were present bilaterally. They contained faint sclerotic borders and at surgery were identified as fatty containing tumors. Pathologic report indicated keratin containing tumors.



Case II, Figure 4

An oblique view shows to better advantage the faint sclerotic border surrounding the cystic lucent change in the mandible. The superior arrow points to caries.

tained this creamy material. Five such small keratocysts were removed from the mandible and maxilla.

Following the surgical procedure there was good healing of the extraction and cystectomy regions in the oral cavity. The healing progressed satisfactorily. The combination of multiple cysts of the jaws, basal cell carcinoma, and skeletal anomalies all were compatible with the diagnosis of basal cell nevus syndrome.

The interesting facet of this case is that clinically at the outset, with multiple skeletal anomalies and cystic lesions of the mandible and maxilla being present, a presumptive diagnosis of basal cell nevus syndrome was made. Corroborative evidence was, at first, not obtained. It was only with persistence, because of the clinical findings, that a further search by the dermatologist revealed the presence of basal cell carcinomas.

This syndrome was first described by Binkley¹ in 1951. Evidence indicates that this is a heritable disorder. It may be related to other neoplasms. In this syndrome, there are progressively large numbers of basal cell tumors appearing on the skin over the years, beginning even in childhood. Major systems or organs in which defects have been noted are the cutaneous, osseous, ophthalmologic, and central nervous systems.

It is believed that the dominance is highly penetrant and of random distribution. It is still considered autosomal, however, as it appears to have no particular affinity for either sex. Taking a family history may be useful before making diagnosis of basal cell nevus syndrome.

The term *nevus* should be used to report a congenital abnormal growth of cells present at birth or their anlage. This, of course, excludes basal cell tumors which have been acquired through actinic exposure, although their pathologic appearance is similar. At times, multiple basal cell nevi are present. It may be difficult to identify a basal cell tumor in a patient even after careful search. However, with the multiple findings in the other major systems, a diagnosis which may be tentative at best, can be later supported with the development of basal cell nevi, (singly or in

multiple regions) throughout the skin surface. Basal cell epitheliomas may occur in childhood, but ordinarily they become manifest about the time of puberty or in the last half of the second or first half of the third decades.

A characteristic facies appears to be part of the syndrome but need not be present in every case. This is produced by "bossing" of the parietal and frontal bones which is quite marked and gives the skull a pagetoid appearance, with well developed supraorbital ridges which results in a sunken appearance to the eyes. A true ocular hypertelorism may be present in association with a broad nasal base. Mandibular and maxillary cysts are almost as constant a defect as the basal cell tumors are in this syndrome. They may antedate the development of the cutaneous lesions by several years and they may be difficult to locate.

Palmar dyskeratosis has also been described. The nevi are usually numerous and have a flesh colored to brownish colored nodulation on the face and trunk. The basal cell nevus exhibits a wide diversity of histopathologic appearances, with the entire spectrum ranging from that of a distinct aggressive ulcerating basal cell carcinoma to that of a benign adnexal tumor. A characteristic palmar-plantar dyskeratosis has been noted in several patients. These are punctate lesions, the central core of which falls out, leaving a well circumscribed rather red purplish depression.

The skeletal system is significantly involved. The most common anomaly is bifurcated rib. This may involve several ribs or may be bilateral. Kyphoscoliosis and spina bifida may also be noted. Synostoses of the ribs, partial agenesis and cervical rudimentary ribs are sometimes found in the vertebral column. Shortening of the metacarpals (brachymetacarpalism) has been identified. This may produce a dimple instead of a knuckle clinically when the hand is completely flexed into the fist position.

Invariably, all these patients will demonstrate odontogenic tumors. Jaw cysts appear to be a constant feature in this syndrome. They are usually classified as primordial cysts or odontogenic keratocysts. One of the present cases, a calcifying non-odontogenic myxoma is being reported for the first time. Defective dentition characterized by markedly carious and misshapen permanent teeth that require early extraction is also present. Central nervous system changes may include mental retardation. Electroencephalographic changes have been described. Calcification of the dura, agenesis of the corpus callosum and medulloblastomas have also occurred.

Patients with the basal cell nevus syndrome share certain clinical and metabolic features with other persons who have pseudohypoparathyroidism. These findings with patients who have round facies, short digits, mental retardation, and un-responsiveness to parathyroid extract (pseudohypoparathyroidism) in the basal cell nevi-jaw cyst syndrome link these two defects. The short stature, however, is not an essential or pathognomic finding.

Other findings include keloid, supernumerary nipple, polydactyly, arachnodactyly, syndactyly, oligodactyly, acrocyanosis, hypohidrosis, inguinal hernia, congenital cataract, deformed clavicle, pes planus, deformed scapu-

la, cleft lip, kidney malformations, and malrotation of the bowel.

Summary

The basal cell nevus syndrome is a clinical triad with osseous involvement, mandibular odontogenic cysts, and basal cell nevi. All of the components of the syndrome may be present at any one time but the development of nevi may lag behind the appearance of abnormalities in other body systems. Diagnosis depends on the roentgenographic demonstration of osseous abnormalities, plus clinical correlation with the superficial defects that the patient may have, and a positive pathologic diagnosis of basal cell nevi.

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176 Palisade Avenue

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tured the essence of the confusion and misunderstanding that inhibits many people from donating blood. The film shows actual blood donation, how simple it is, and the time it takes. The film has already won the Silver Medal at the New York International Film and TV Festival for 1970, and stands ready to provide a strong tool for motivation of new donors.

IF MORE MEN CRIED

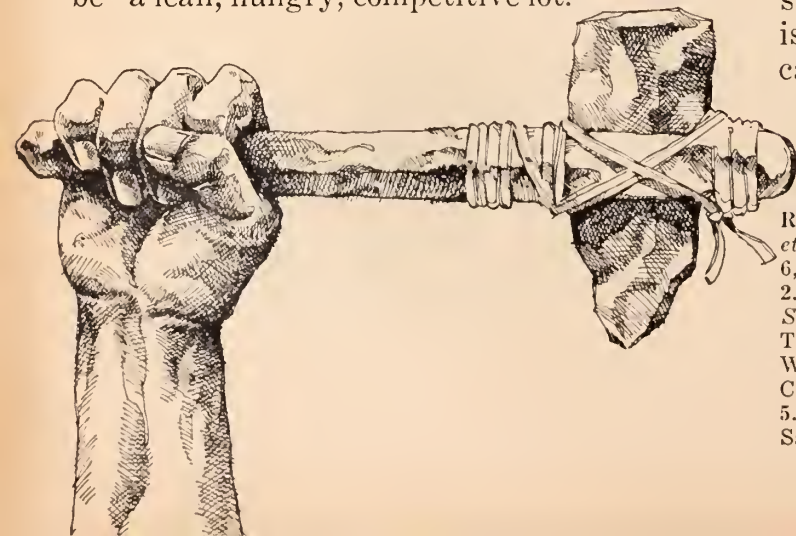


At least seventy-five out of one hundred adults with duodenal ulcers are men.¹

Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."²

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."²

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."³



Big boys don't cry. If more men cried maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total



of their genes and what they are taught. Schottstaebgen observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.⁴ Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.

Take away stress, you can take away symptoms

There is no question that stress plays a role in the etiology of duodenal ulcer. Alvarez⁵ observes that many a man with an ulcer loses his symptoms the day he shuts the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

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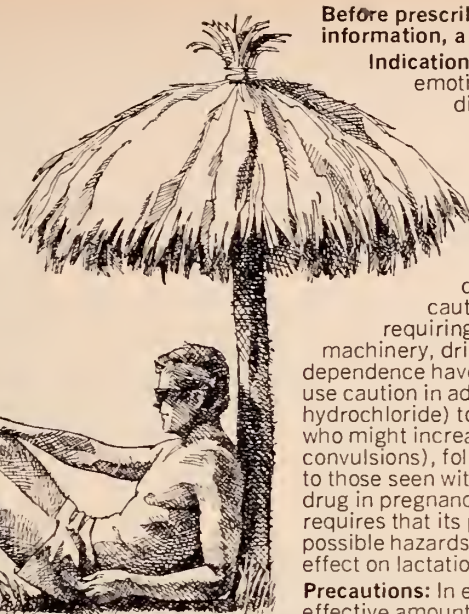
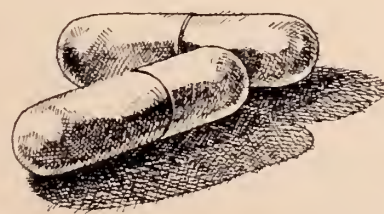
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Indications: Indicated as adjunctive therapy to control
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Contraindications: Patients with glaucoma;
prostatic hypertrophy and benign bladder
neck obstruction; known hypersensitivity to
chlordiazepoxide hydrochloride and/or
clidinium bromide.

Warnings: Caution patients about possible
combined effects with alcohol and other CNS
depressants. As with all CNS-acting drugs,
caution patients against hazardous occupations
requiring complete mental alertness (e.g., operating
machinery, driving). Though physical and psychological
dependence have rarely been reported on recommended doses,
use caution in administering Librium (chlordiazepoxide
hydrochloride) to known addiction-prone individuals or those
who might increase dosage; withdrawal symptoms (including
convulsions), following discontinuation of the drug and similar
to those seen with barbiturates, have been reported. Use of any
drug in pregnancy, lactation, or in women of childbearing age
requires that its potential benefits be weighed against its
possible hazards. As with all anticholinergic drugs, an inhibiting
effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest
effective amount to preclude development of ataxia, over-
sedation or confusion (not more than two capsules per day
initially; increase gradually as needed and tolerated). Though
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psychotropics seems indicated, carefully consider individual
pharmacologic effects, particularly in use of potentiating drugs
such as MAO inhibitors and phenothiazines. Observe usual
precautions in presence of impaired renal or hepatic function.
Paradoxical reactions (e.g., excitement, stimulation and acute
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impending depression; suicidal tendencies may be present and
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sias (including agranulocytosis), jaundice and hepatic dys-
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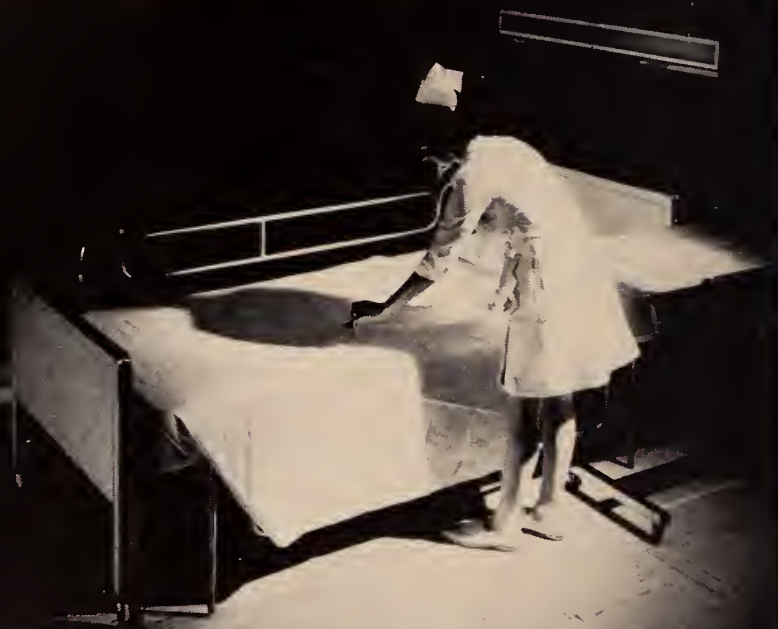
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Cholecystocolic fistulae are rarely reported, yet they are recognizable and their diagnosis may save lives.

Diagnosis Of A Cholecystocolic Fistula By Sigmoidoscopy And Serendipity*

**John A. Ianacone, M.D. and
George L. Becker, Sr., M.D./Paterson**

This report of a cholecystocolic fistula should focus the doctor's attention on a serendipitous finding. This led to a final diagnosis which facilitated pre-operative preparation and treatment. It reminds us all to be on the alert for just such unusual and important features since most of these fistulae are not diagnosed prior to surgery.

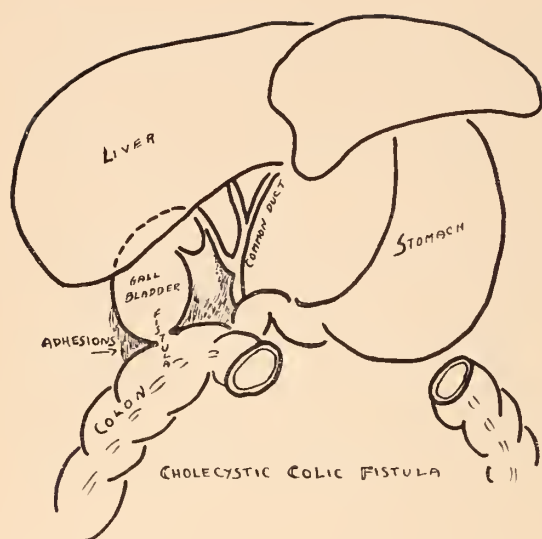
Internal biliary fistulae involving the gastrointestinal tract are not rare, yet relatively few cases have been reported throughout the world. Most of the reported cases are in older individuals and are reported by the larger clinics rather than in private surgical practice.² The disability caused by these fistulae is often best treated by surgical correction even though the mortality rate is far greater than in those patients requiring uncomplicated cholecystectomy. Irreversible changes may take place in the liver causing these patients to be poor operative risks.³ We do not know the actual frequency of biliary enteric fistulae and, in particular, we do not know how many are discovered by the proctologist (as happened in this case) but the incidence must be rising because of the increasing longevity of our population and increasing incidence of biliary calculi.

At the Mayo Clinic in a five year period (1945 to 1950) 84 patients were operated upon. This represents 0.86 per cent of the total patients treated surgically for biliary

tract disease. At the New York Hospital, Cornell Medical Center, in a 24 year period (1932 to 1956) 40 cases were encountered in over 4,500 patients treated for biliary tract disease.³ In one report³ the incidence of biliary enteric fistulae was cited as 0.3 per cent of autopsies of persons 50 years of age and over. In another series,⁴ the pre-operative diagnosis was made in only two of 153 cases of cholecystoenteric fistulae.

Diagnosis of internal biliary fistulae is not usually made prior to surgery but often only at surgery or autopsy. The passage of a gallstone *per anum* suggests an abnormal outlet from the gallbladder. The x-ray visualization of air in the biliary tree is an important finding in noting an abnormal connection between the biliary tree and the gastrointestinal tract. However, the possibility of air producing bacteria in the biliary tree must be considered. The pathognomonic finding of pre-operative cholecystocolic fistula is the passage of barium into the biliary tree following barium enemata. Yet, the tract may not visualize as happened in the present case report. It was thought that the small opening with possible edema prevented the barium from entering into the biliary tree but the x-ray did cast a shadow which presented a funnel effect. In a Connecticut case⁵ it was thought that a large mass of granulation

* From the Department of Surgery, Paterson General Hospital, Paterson, New Jersey. This paper was read by invitation at the Northeastern Proctological Conference in Atlantic City, October 30-31, 1969.



It was thought at one time that biliary enteric fistulae were pathological curiosities but we now consider them a life saving process after perforation of a gallbladder since fatal bile peritonitis could occur with discharge into the free peritoneal cavity.

Conclusion

The diagnosis of a cholecystocolic fistula is rare and not usually made pre-operatively. The only pathognomonic sign is its finding by barium enema x-ray. Since this finding

may not be demonstrated, this serious possibility should be considered regardless of the presence or absence of signs and symptoms referable to such an entity. The case here presented with the discovery of a gallstone by sigmoidoscopic examination alerts one to the increasing need of vigilance at all times.

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310 Fifth Avenue

Radio Service For Physicians

The Federal Communications Commission has approved an application for local medical societies to operate special emergency radio services for their members. These hookups could carry only messages relating to the safety of life or urgent medical duties of users. Such emergency radio service must be cooperative, with members assessed *pro rata* shares for cost of operation. At present individual physicians have been allowed to use emergency radio frequencies and to form groups of physicians for such hookups, but societies representing all physicians in an

area have been restricted by FCC regulations. In its new ruling the FCC explained that: "There is merit in the plan to use these stations on a coordinated basis with telephone answering services now operated by medical societies and to dispatch messages from central points where society records are readily available to assist in locating a physician when called. . . . The proposal gives promise of fostering opportunities for service in rural regions. . . . This also permits the establishment of parallel systems for emergency communications . . . for use in national crises."

Communicating hydrocephalus is a not uncommon, but rarely thought of, factor in progressive memory defect and confusion of the pre-senile

Cerebral Arteriosclerosis

A Non-Cause Of Dementia

Matthew Menken, M.D./New Brunswick

Impairment of intellectual function in middle and late adult life often occurs in the absence of other apparent neurologic signs and symptoms. Such patients are difficult to evaluate clinically, and ancillary tests (such as a brain scan and electroencephalogram) seldom offer much guidance. In recent years clinical and neuropathologic studies have shed some light on the morbid process that accounts for the clinical picture in most instances. From these, it is apparent that the clinical label most frequently used, cerebral arteriosclerosis, is often without justification.¹ Because the clinical histories are often stereotyped, a hypothetical case presentation is included as a paradigm.

A 62 year-old man has been under the care of his physician for several years with a modest degree of hypertension, usually in the range of 150/100. He has an abnormal glucose tolerance test and a mildly elevated postprandial blood sugar. Over the past two or three years, his family has noted a progressive loss of memory, worse in the last few months. Recently he has become suspicious, withdrawn, and repetitive in conversation.

"He seems to be living in the past" and, in lay terms, he is frankly senile. The general physical examination is normal, except for mild hypertension and cardiomegaly. The patient cannot give the correct year, or name of the president. He categorically denies that there is anything wrong with his memory. He jokes that he is "not nuts," or says that he "does not follow politics." He may become

angry with the examiner. Further tests of mental function reveal a shortened attention span, inability to abstract as in calculation, poor judgment, and, most prominently, an impaired ability to learn new information. There are no cranial nerve, motor, or sensory deficits and the deep tendon reflexes are normal or slightly exaggerated; there are no pathologic reflex signs.

These patients have generally been labeled "cerebral arteriosclerosis," the implication being that arteriosclerosis, diabetes, and hypertension have reduced cerebral blood flow, with or without small strokes, and have produced the clinical picture. Yet, in the majority of the cases when the brains of such patients are examined at post-mortem, the pathologic process is that of pre-senile dementia (Alzheimer's disease)².

The arbitrary age cut off of 65 for this disease is without any clinical usefulness, because older patients with the same history have exactly the same pathologic process, which is then called senile dementia. The brain is atrophic and microscopically shows senile plaques and neurofibrillary tangles.

Possible causes of dementia are many and include endocrine disturbances, metabolic derangements, and various mass lesions (bilateral subdural hematomas being the entity most frequently mentioned in this connection). Occasionally a retarded depression presents as a pseudo-dementia. Nonetheless, these causes are quite unusual with the history presented above.

* From the Middlesex General and St. Peter's Hospitals, New Brunswick, New Jersey, and Princeton Hospital, Princeton.

Dementia on the basis of many "small strokes," without appropriate history or demonstrable evidence on examination of involvement of the bulbar, motor, or sensory pathways, is exceedingly rare. Patients may not have a clear history of hemiparesis, but a careful review will often reveal one or more abrupt episodes of a clumsy hand, thickened speech, or a disturbance in vision which then gradually cleared. Occasionally a sudden occlusion in the distribution of the posterior temporal artery may lead to an abrupt change of memory, but the history will rarely be confused with that presented.

The diagnostic distinction is no longer without therapeutic implications. When atherosclerotic disease is felt to be responsible for a patient's symptoms, attention is directed to the extracranial vessels, particularly the bifurcation of the common carotid arteries, and an unnecessary arteriogram may be undertaken which carries significant morbidity in this age group.³ Attention instead should be focused on the pathways of cerebrospinal fluid circulation. Several series of patients have now been reported who are almost identical with the hypothetical case described, and who are discovered to have a communicating, low-pressure hydrocephalus.⁴ It is said that the patient with this entity, in addition to dementia, shows a "magnetic" type of gait. That is, they walk as if the feet

were glued to the floor. In practice, this disturbance is often difficult to distinguish from the hesitant, short-stepped gait so common in the older patient. Spinal fluid pressure and protein are usually within the normal range, yet at pneumoencephalography air enters a dilated ventricular system and fails to be seen over the convexities of the hemispheres.

Isotope cisternography has been tried in an attempt to screen those patients with dementia who may have communicating hydrocephalus.⁵ Several patients have made dramatic recoveries following appropriate spinal fluid shunting procedures.⁴

Accordingly, patients with progressive dementia warrant neurologic investigation, but only rarely will vascular disease be found to be of pathogenetic relevance.

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Federal Responsibility For Direct Medical Care

If the state and county medical societies certify that such a program is locally needed, the federal government now has the authority to expand the U. S. Public Health Service to provide direct medical and other health care in ghettos and rural areas where there are shortages of physicians and health personnel.

The Senate approved the authorizing legislation, 66 to 0, and the House by an almost unanimous voice vote. President Nixon signed

it into law on December 31, 1970. The Secretary of Health, Education and Welfare, and the U. S. Public Health Service Surgeon General had asked Congress to defer action until the President had presented his over-all health program early this year. The legislation authorized \$10 million for the current fiscal year ending June 30, \$20 million for fiscal 1972, and \$30 million for fiscal 1973. The money must be appropriated before it is available for the program.



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Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain^{1,2,3} leading to this conclusion, and one⁴ in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors,

some of them malignant, in five species of sub-primate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfolobomphthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov.) 1969. 1A2

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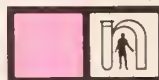


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Dr. White was at Cornell, 1921 to 1925. He had personal contact with some of the giants of that decade. Here is a corner of medical history seen through the eyes of one who was there.

James Ewing, Douglas Symmers, and Paul Klemperer*

Personal Recollections

Thomas J. White, M.D./Jersey City

Let me present my superficial recollections concerning three pathologists to whom I have been indebted—Drs. James Ewing, Douglas Symmers, and Paul Klemperer.

James Ewing

My introduction to Dr. Ewing occurred in 1922 as a second year student at Cornell University Medical College. He was Professor of Pathology and a recognized authority on the subject of cancer. At our first session, he wrote upon the blackboard the names of a few textbooks of pathology which he recommended—Delafield and Prudden was one of these—and while his back was turned, his assistant, Dr. Elise L'Esperance, added an additional title: "Neoplastic Diseases—Ewing." He turned partly, reached for an eraser, obliterated the reference to his work without comment and continued his talk to the class. It was a gesture of devotion on the part of Dr. L'Esperance and a typical humble reaction from Dr. Ewing who realized that this was not a *must have* book for second-year medical students.

He taught microscopic pathology two hours daily for most of our sophomore year, assisted by Dr. L'Esperance. He customarily stood before the class on a slightly elevated platform and briefly summarized the characteristics of a disease—etiology, pathology, symptomatology, and gave pertinent details concerning slides about to be distributed. This would

consume ten or fifteen minutes. Then he would walk about the room, sit with a student, look into a microscope and answer questions. He then returned to the platform, advanced his subject a bit further—then, more slides, more walks among the students. If an interesting general comment was in order, he would return to the platform, bring the class to attention always in the same manner by calling "Gentlemen," and make his observation. (Incidentally, we had a goodly number of lady students included among the gentlemen.) One day slides had been distributed to show an aspect of gastric ulcer. After viewing the slide of a student, Dr. Ewing went to the platform, alerted the class with "Gentlemen," and announced that he had just detected a clump of malignant cells in a section he had been distributing as representative of gastric ulcer for the previous twenty years.

Better to "peg" the various types of disease, Dr. Ewing would single out a case history, outline the circumstances of death, describe the specific pathologic lesions, and distribute slides for study. Thus, a trolley car motorman was electrocuted while reversing the pole connecting his car to the overhead trolley wire. Acute renal changes would be recalled as exemplifying the "motorman's kidney." (I fear that this reference to trolley cars and motormen may, in the year 1970, convey no more a

*Read at the Graduation Dinner for Resident Pathologists, Harrison S. Martland Hospital, New Jersey College of Medicine, 26 June 1970.

picture to a fledgling pathologist than the term "water hammer pulse" to a budding cardiologist!)

Dr. Ewing also served as medical director of Memorial Hospital, then located at 106th and Central Park West. His responsibilities in this position, with teaching, writing, and research made a very full day for a man who was frail and not in robust good health. He had a small office at the medical college where much of his study and research was conducted, usually at night and until the late hours. (His wife had died many years before—three years after their marriage). He was afflicted by frequent attacks of *tic douloureux* which would persist for days during which he never mentioned his pain, nor deviated from his schedule. He was considered the final arbiter concerning the pathologic diagnosis of cancer. Microscopic sections were sent to him from all parts of the world for opinion: "Ewing says it is (or is not) cancer" would be the final decision.

He impressed one as a very reserved sort of person, but neither cold nor inaccessible. He showed neither foibles nor eccentricities nor affectations. He could be sharp and cutting in his rejoinder to his colleagues and to others but never to his students. He rarely smiled, laughed, or raised his voice, but his expression was not glum and one felt that he had all the nice personal characteristics but that they were not discernible by his expression. Each school has its ideal teacher. James Ewing was unquestionably such to Cornell Medical College students from the foundation of the school in 1899 until his retirement in 1932 and the removal of the college from First Avenue and 28th Street to its present location at York Avenue and 68th Street.

Mention must be made of his loyal and sole assistant, Dr. Elise L'Esperance, an outstanding pathologist in her own right. For more years than I can estimate, she was his good right arm and helped in every way to make his burden light. After his death in 1943 and until her own, she perpetuated his memory in many ways. Incidentally, she founded the

Strang Cancer Detection Clinic, named in honor of her mother, Kate Strang, a daughter of New York's famous Chauncey Depew.

Douglas Symmers

Dr. Douglas Symmers served at Bellevue Hospital, across the street from Dr. Ewing. A South Carolinian, graduate of Jefferson Medical College in 1901, he had been Pathologist and Director of Laboratories at Bellevue and Allied Hospitals since 1918 and later was Professor of Pathology at New York University and at Cornell Medical College. I first recall him in 1922 when he performed a teaching autopsy for a small section of our class. The patient, observed by us clinically, was a heavy-set middle-aged man, suffering from a nephrotic glomerulonephritis. He was a large, pale man with generalized edema. Dr. Eugene DuBois, then an instructor and later Professor of Medicine at Cornell and an authority on metabolism, accompanied us to the autopsy room. Dr. DuBois was a quiet, reserved, scholarly man, not—as they say—given to levity. A student summarized the case history as Dr. Symmers began the autopsy. Dr. DuBois, in keeping with Dr. Ewing's "pegging" of kidney disease, indicated that in this large, pale edematous man we would likely find large, pale, edematous kidneys. As Dr. DuBois was predicting the appearance of the kidneys, Dr. Symmers was removing them. He passed them to us and remarked to the formal Dr. DuBois, "Gene, I hope *your* kidneys look as good as these." Dr. DuBois, with unexpected humor, answered, "Doug, I hope yours work better." (Dr. Symmers, a bachelor, lived rather well.)

I came to know Dr. Symmers better in 1925. As senior students, we were allowed to choose an elective subject, and for the first time, he offered a month of pathology. Three others and I accepted the opportunity. It proved to be the most fruitful month I ever spent in medicine and, incidentally, it took up so much of Dr. Symmers' time that he never again gave the elective. He arranged for the residents of all four hospital divisions to notify his office of terminally-ill patients with interesting findings, such as palpable tumors,

obscure diagnostic problems, and so on, likely to come to autopsy. Residents throughout the hospital regarded Dr. Symmers highly and cooperated fully. Our group would visit a ward, examine the patient together with Dr. Symmers and discuss the condition with him. His knowledge of clinical medicine was astonishing, particularly concerning tumors, obscure diseases, skin lesions, and syphilis. His discussions on the wards were a joy to hear.

I recall that he had clinically observed an appreciable number of patients with anthrax at Bellevue and had made pathologic studies of the disease. He demonstrated that the then accepted method of incising the primary lesion was not only ineffective but severed the gelatinous-like barrier which formed locally beneath the skin. He noted that most of the afflicted patients were derelicts from the nearby Bowery with anthrax lesion on their necks. He visited the Bowery and purchased some of the very cheap shaving brushes sold there for about ten cents. From them he cultured the anthrax bacillus. He reported his findings in the *Journal of the American Medical Association* in 1921, and following his exposé, New York State enacted a law to require the sterilization of all shaving brushes regardless of price. The incidence of anthrax dropped markedly in New York City.

This instance illustrates only an incidental and possibly not commonly recalled "by-line" in Dr. Symmers' journey as a pathologist. In my own uncritical view, I would suggest that his major contribution related to the pathology of certain types of lymphomata. He differentiated benign giant-cell lymphadenopathy from Hodgkin's disease, and this condition has come to be known as Brill-Symmers disease.

The mention of anthrax recalls an incident which illustrates the fallibility of all of us and Dr. Symmers' deep feelings. On a morning soon after our arrival at his office in the pathological department, he received a telephone call from Gouverneur Hospital indicating that they had a suspected case of anthrax and that they would like to have a consulta-

tion by Dr. Symmers. He invited us to accompany him. He had already fully demonstrated anthrax to us at Bellevue, both clinically and bacteriologically, with the typical *caput Medusae* on the culture plate, and pathologically by inoculations of material from the patient's lesion into a mouse. He stressed that if there is any such thing as a typical lesion in medicine, it is that of anthrax. The patient at Gouverneur Hospital was a young man, obviously seriously ill, feverish, toxic, with a blackish lesion on his neck, surrounded by an extensively swollen, indurated area. Dr. Symmers inquired if he had used a new shaving brush. The answer was no. After careful examination, he gave his opinion that this was not anthrax. The attending physician inquired if anthrax antiserum should be given, "just in case." Dr. Symmers appeared not to hear. When the question was repeated, he sharply replied that since this was not anthrax, why give serum?

The following day, another telephone request came to see the patient—he had worsened. During the drive to the hospital, Dr. Symmers remarked that he was prepared to eat crow, and the patient indeed looked worse. Again he could not call the lesion anthrax, and we left. Shortly after nine of the third morning, the telephone rang. Dr. Symmers went into the office to answer it, and came out looking deadly. "That was the pathologist from Gouverneur," he said, "the patient died during the night. The blood cultures revealed anthrax bacilli and sections demonstrated the liver and spleen to be riddled with anthrax bacilli." He dismissed us for the day and returned to his office.

Eight years later, I encountered him for the first time since my student days. His first remark, after greeting me, was, "White, do you remember the case of anthrax I missed?" This episode, aside from its moral for all of us, only vaguely indicated the intensity, warmth, and emotional side of Dr. Symmers.

He never used gloves at autopsy and forbade them to his residents: without them, the hands would be rinsed frequently; with them,

one could become careless, he said. During an autopsy, his enthusiasm and volubility, his colorful remarks, expressions, and reactions were a pleasure to see. I recall that we had examined a young girl dying from proved pulmonary tuberculosis and with tumor in the splenic area. It seemed to all concerned that this was an enlarged spleen due to miliary tuberculosis. At autopsy, pulmonary tuberculosis was indeed present, but the tumor was a retro-peritoneal sarcoma. Dr. Symmers dropped his knife and appealed to heaven to grant enlightenment to poor groping clinicians, but not quite in so simple terms.

An incident comes to mind which may add an interesting local Bellevue historical note. He had performed an autopsy on a young woman with pernicious anemia. Nothing of importance was found and he bemoaned the lack of information the autopsy had produced. This was in May 1925. About that time, we had a New York City police officer patient with pernicious anemia admitted to the hospital for one of the many blood transfusions he had been receiving periodically. Dr. DuBois, then Director of the Second Medical Division, received a personal letter from Dr. George Minot indicating that he had observed remission in patients with pernicious anemia when fed liver in large quantities and suggested that Dr. DuBois try this therapy. As directed, the police officer received approximately one-half to one pound of liver three times daily. I don't recollect the interval of time required, but we saw him blossom forth with the ruddy cheeks of a New York traffic policeman. This was prior to Dr. Minot's published report, in 1926, of the effective use of liver in pernicious anemia. I recall Dr. Graham Lusk remarking that among the clinical notes by Dr. Theodore Janeway, the renowned Bellevue clinician, examined after his death in 1917, the doctor had mentioned that patients with pernicious anemia who enjoyed taking large quantities of liver had seemed to improve. He had not pursued this observation.

Dr. Symmers was at Bellevue at the time the office of the New York City Medical Examin-

er was established. He gave vigorous, outspoken support to the drive which resulted in the termination of the coroner's office in 1917. This served as a model for the development of forensic medicine throughout the United States. The towering Dr. Charles Norris became the first Chief Medical Examiner with a staff of brilliant pathologists around him.

Among them was Dr. Otto Schultz who often supplied material for the current murder mystery stories, and such young men as Dr. Harrison Martland and Dr. Milton Halperin, the present Chief Medical Examiner.

I had no association with Dr. Symmers subsequent to 1925, and I would hear of him only indirectly through his associate, Dr. Armin V. St. George, who was pathologist at the Jersey City Hospital, and mostly I recall hearing of his vicissitudes.

Paul Klemperer

Dr. Paul Klemperer received his medical degree at the University of Vienna in 1912. While initially studying law, he attended the lectures of Dr. Sigmund Freud and became interested in psychoanalysis and turned to the study of medicine. He intended to become a general practitioner, but took some training in pathology and became an assistant to Dr. Carl Sternberg. He entered the army in World War I as a medical officer and his duties were involved with pathology. Subsequently, when Dr. Sternberg did not receive the Professorship of Pathology at Vienna, Dr. Klemperer came to the United States in 1921. He served briefly as pathologist at Loyola University in Chicago, then at Post-Graduate Medical School in New York City until 1927. He had been pathologist to Mount Sinai Hospital and Professor of Pathology at Columbia University College of Physicians and Surgeons for a relatively short time when I first met him about 1930.

A physician of my acquaintance was forming a group of five physicians interested in a private course in medical pathology to be given by Dr. Klemperer and he invited me to join.

This course was given in the pathological department at Mount Sinai Hospital. Subsequently, I became acquainted with Dr. Klemperer both professionally and personally until his death in 1964. Like the other pathologists already mentioned, my acquaintance was, unfortunately for me, only a superficial one. I recall Dr. Klemperer as having opened to me an informative and never-to-be forgotten view of the field of pathology.

Prior to our arrival at the hospital, an autopsy would have been completed during the night by his staff. Dr. Klemperer would summarize the pertinent clinical findings without referring to the chart. Then he would demonstrate the autopsy material and recall and correlate both the symptoms and the pathologic findings. In advance, he would have selected from the pathologic museum specimens to demonstrate the variants of the chief pathologic findings. Thus, if lymphosarcoma were found, he would follow the presentation by showing specimens illustrating focal and diffuse types of this disease.

Aside from the wealth of information conveyed to those such as myself exposed only to a surface knowledge of pathology, Dr. Klemperer gave an impressive demonstration of the perpetuation of the Vienna tradition in the teaching of pathology. He impressed me by the vivid manner in which he could describe the objects of his demonstration; his wide range of descriptive terms, and his concise English were notable even as he pointed out details which would escape a less trained eye. That he was an intelligent man, a deep thinker, and was able to express himself very clearly *can* be well documented by the writings and observations he left as his legacy to medicine, particularly concerning collagen-vascular diseases. He was a kindly man, one who loved to teach, patient, smiling, always approachable.

Dr. Sadao Otani became his assistant at Post-

Graduate in 1925 and came to Mount Sinai with him. Their association continued until Dr. Klemperer's formal retirement in 1955. Dr. Otani became an acknowledged master of surgical pathology, but with complete self-effacing devotion, he made it possible for Dr. Klemperer to have relative freedom from routine duties.

In 1960, a few years before his death, I encountered Dr. Klemperer one afternoon at the library of the New York Academy of Medicine. He was then in retirement, and preparing a paper on the history of pathology. He apparently wished, at the time of our meeting, to relax and invited me to sit and chat with him. He brought up the subject of medical education, and spoke at length and with feeling about it. He indicated that, as a young physician in Vienna, he had planned to be a general practitioner. However, circumstances had brought him into the field of pathology, yet his interest in the practice of medicine had never ceased. He was concerned about the many well-trained young men who were turning away from the practice of medicine into full-time positions. He regretted the loss to medical teaching of the clinician who went from bed to bed, examined patients, and recited his experiences. Dr. Klemperer ended the conversation by remarking that he had just been reading a reference by Morgagni who said that he had widened his view of pathology by standing on the shoulders of the giants who had preceded him. Dr. Klemperer sadly remarked, "From where shall arise the giants of clinical medicine on whose shoulders future generations will stand?"

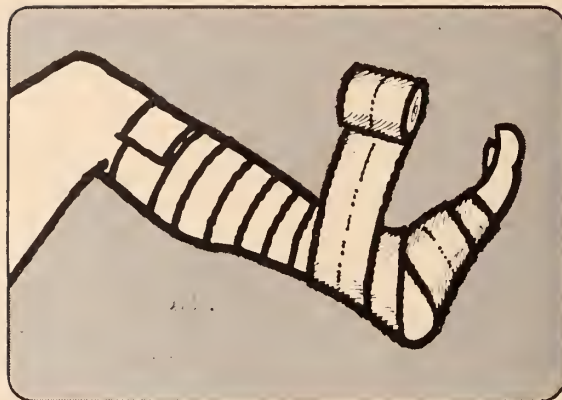
I have presented a crudely-drawn, poorly-outlined vignette of three prominent pathologists, all worthy of recall and each of whom touched my life. As pathologists, you very well know their contributions to medicine and to science. I hope that when their names recur in your reading, my superficial recollections will add substance to their shadow.

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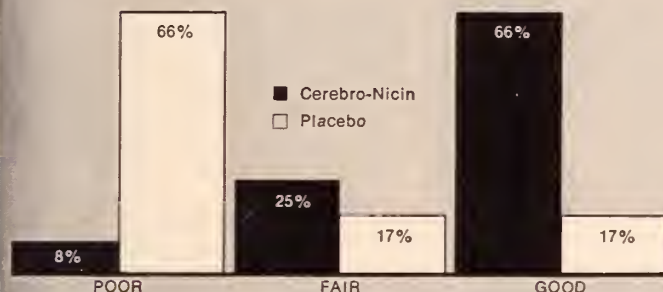
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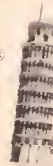
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Android-HP HIGH POTENCY

Each red tablet contains:
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Thyroid Est. (1 1/2 gr.)... 30 mg.
Glutamic Acid... 50 mg.
Thiamine HCL... 10 mg.
Dose: 1 tablet 3 times daily
Available:
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Android-X EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone... 12.5 mg.
Thyroid Est. (1 gr.)... 64 mg.
Glutamic Acid... 50 mg.
Thiamine HCL... 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone... 2.5 mg.
Thyroid Est. (1 1/2 gr.)... 15 mg.
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Thiamine HCL... 25 mg.
Glutamic Acid... 100 mg.
Pyridoxine HCL... 5 mg.
Niacinamide... 75 mg.
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Vitamin B-12... 2.5 mcg.
Riboflavin... 5 mg.
Dose: 2 tablets daily
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with pruritus or any causality have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause androgenic nausea, vomiting, abdominal pain, diarrhea, headache, dizziness, lethargy, prosthesis, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema. Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montano, P. and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:95, 1966. 2. Bullock, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tibbitt, A. S. Methyltestosterone-thyroid in treating impotence. Gen Phys 25:1, 1967. 4. Williams, L., Gragow, W. L., Zimet, B., Fukushima, D. K., and Gallagher, T. F. Thyroid androgen interactions and the hypohalesteremic effect of androgenesis. J Clin Endoc 19:936, 1959. 5. Farris, E. J., and Cullen, S. W. Effects of L-thyroxine and hydroxyprogesterone on spermatogenesis. J Urol 79:613, 1958. 6. Ossi, A., and Farver, S. E. United States Dispensary, Inc. 251, Lippincott, Philadelphia 3, 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the male. Thomas, Springfield, Ill. 1959, pp. 79-99.

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NEW JERSEY DOCTORS' NOTEBOOK

Behind The Drug Scene

(This column is prepared by Stanley Einstein, Ph.D., Coordinator, Drug Abuse Project, Martland Hospital Unit, CMDNJ, Newark, and Executive Director, Institute for the Study of Drug Addiction, New York City.)

New and Old Roles for the Physician

The physician, with his role as a medical authority, with the status of an important community leader, is often given many drug abuse related responsibilities, some of which he may be unprepared to assume. At times it is expected that he involve himself in particular activities, because the misuse of drugs continues to be perceived as being primarily a medical problem. Whatever the source of his responsibilities and involvements, the physician must recognize the variety of activities that he may be called upon for under the general umbrella of drug abuse.

Treatment

The treatment of acute and chronic conditions related to the action of specific drugs or to those conditions associated with the manner of drug use as well and the life style of the drug abuser is an obvious responsibility for the physician.

The contemporary drug scene, particularly the pill and hallucinogen scene, raises a number of treatment problems. In the December 1970 issue of this *Journal* an overview of appropriate treatment was described. A comprehensive evaluation was listed as the first part of the treatment process. If the patient is not in condition to describe what drug he has taken (or knows it only by its slang term) the physician may be in trouble. Knowing the signs and symptoms of a given drug reaction is of some help for the comatose patient. Getting information from friends of this patient may be of some more help. The physician can help himself by learning the old and newly added slang drug terms. The street

user of PCP (phencyclidine—a veterinary anesthetic) generally knows it as *hog* or *angel's dust*. A *hot shot* is generally a combination of heroin and lye, the intent being to get rid of a drug user. Hundreds of terms are used to describe contemporary drugs and their combinations.

Whatever treatment goals the physician has in mind, he will have to refer the person on for certain facets of treatment. Notwithstanding the pressured and busy schedules of the physician, he must protect himself and his patient by having a fairly good idea about the "track record" of the agency or person he is making the referral to. Sending a patient to a center which then turns the patient down (for whatever the reason) is sure to affect future treatment negatively. Holding on to a patient and treating him only chemotherapeutically when he has many other needs that necessitate intervention also creates serious problems. There are no chemical solutions to "people problems." Continuous chemotherapeutic intervention may raise the spectre of "He's a scrip doctor," a label which helps no one in a community's treatment system. A proper evaluation and choice of goals permits the physician and the patient to understand what each of their roles and responsibilities must be and which auxiliary services are to be turned to.

More for the physician than for the patient who has been referred on, an active followup system is a necessity. It permits the practitioner to increase his knowledge concerning the types of intervention that appear to work best for specific types of drug abusers and to understand the strengths, limitations, and gaps associated with the agencies.

Another part of treatment that is often "unconsciously" overlooked is that of reporting the drug user to the authorities. These authorities are the State Police or State De-

partment of Health. The issue is whether the physician feels that by *not* reporting his patient he is doing him and his treatment a service. Holding legal and professional issues in abeyance for the moment, let us not forget that most professionals have had difficulties in treating the *invisible* middle class drug abuser, because, until recently, information about drug misuse was primarily focused on the *visible* drug addict.

Methadone maintenance opens another Pandoras' box for the physician. If the medical practitioner uses methadone, he is taking on more than just the responsibility of making available a daily medication and getting information about his patient's abstinence from or use of other drugs. He must make himself (or see to it, that there are other appropriate treatment agents) available for a variety of his patient's needs.

The physician must find the time and the appropriate sources for drug abuse continuing education. His medical society and his hospital are two such sources.

Early Case Finding

The physician must face the issue of having a fairly well worked-out procedure of knowing what to do with the patient. If he does not, he has "spotted" a potential problem for which he has no potential solutions. "Tagging" the drug abuser tends to jeopardize him, which may be medically defensible, as it is with a variety of contagious ailments, if we can offer the person some meaningful alternatives other than just the status of being a patient. Early case finding tends to focus primarily upon the person with the symptoms. But drug misuse has two sources for its constituency—the actual drug user as well as the abstinent person whose daily functioning can be deeply affected by his concern over a drug user to whom he is related. This person has a significant drug problem, which is made more significant by the fact that he rarely has a knowledgeable person to whom he can turn for information as well as a sounding board for his concerns. The physician can be just

the person for this concerned individual to turn to. Early case finding takes on the specific role of assessing the signs and symptoms of *excessive concern* with drug use and provides the information and alternatives that are available for both temporary and long term solutions to this concern.

One variation of early case finding which should involve the physician is the "Hot Line." Whether a confidential hot line is created specifically for drug problems or for other problems, drugs will become a major part of its daily focus. Many of the questions asked and requests made to the volunteers manning the phones are best handled by the physician. The private practitioner cannot be at the phones for any substantial amount of time. On the other hand, in each community which already has or plans to develop a hot line the physician should become involved in both policy development and as part of a back-up team for referral, as well as more direct forms of intervention. The question whether the physician can afford to do this is really a trap. He can't afford not to. Once the hot line is operative, one way or another, the physician or his colleagues in a given community will have to respond to some of the consequences of what is done on that hot line. Inappropriate crisis intervention is more costly in terms of lives, time, and money than appropriate intervention.

Education

Now that the youth of our state are about to be "saved" from drug abuse through hastily put-together drug abuse prevention programs in schools, (and more and more of the nation's media are communicating a variety of facts about drugs use) the physician should prepare himself for becoming involved in both traditional and untraditional medical roles.

The physician will be called upon to treat acute drug reactions. As a result of his assessment and treatment he may have to decide whether the student should be permitted to return to school, be dismissed or suspended, or be educated in special schools and/or pro-

grams. Whether the physician's recommendation is used, we must keep in mind that there are no empirically based guidelines for any kind of decision. Related to this type of recommendation is the request for ascertaining whether a student is a drug user. Using the most sophisticated available tests (and forgetting the issue of false positives and false negatives) we must remember that tests at best indicate that a person is using certain drugs at the time of the testing. No test indicates that a person is a drug addict or drug abuser. This is important because schools are rarely concerned about the consequences of drug misuse for the person; they are much concerned about preventing the "contagious" spread of drug use in school. On the premise that drug use is a contagious disease, schools ask the physician to provide the medical rationale for removing the student from institutionalized education. Again, there are no easy answers to this dilemma, but the physician should know full well that his findings may be used as well as misused. Directly related to this is the role that the physician may have (indeed may demand) in the development of relevant school policies regarding the alternatives available to intervening in drug use both on and off school property. Since policies will be made, the physician's perspective should be included. If the physician chooses to abdicate his involvement in this important area, he has no one but himself to blame, when ratified policies seem inappropriate or involve him in roles he is unprepared for and/or unwilling to take on.

The knowledgeable physician has much to offer the school personnel in in-service training as well as the student body. Exposing myths, acknowledging gaps in knowledge and telling the facts, reviewing available treatment resources, and communicating a sense

of hope can effectively counter the contemporary state of simplistic solutions, apathy, and despair that is all too pervasive in this area. What holds true for the school also makes sense for society's other institutions, such as the corporation, religious bodies, and service groups.

Research

A statement about any number of people misusing drugs in a community will start the machinery of hysteria operating and will give rise to immediate simplistic interventions. The physician can play a significant role in his community by appropriately evaluating the survey and raising relevant questions and possible courses of action. Through his medical society and his other professional affiliations he may want to raise questions about the relevancy of the kinds of research that are being presently financed locally and nationally, using public funds. For example, as important as it may be to discover the toxicity of cannabis and its derivatives, if no evaluation is being made of the drug abuse treatment resources in one's community, the physician can surely raise the issue of research priorities.

If only limited research and evaluation funds are available, we should know if the available resources for treatment and education are effectively doing their job and how we can best help them. Are we to rely on getting more data on how dangerous a drug is, as the solution for drug abuse?

Many more issues should be raised concerning actual and potential roles for the physician in the area of drug abuse. From time to time, more of them will be greatly appreciated. The real issue is not the specificity of a role, but is rather the parameters of the many various roles.

205th ANNUAL MEETING

May 15-18, 1971

Haddon Hall

Atlantic City

Oral Antidiabetics

At the end of 1970 a committee of physicians experienced in the treatment of diabetes met in Boston to indicate their concern over the diabetics taking oral agents who had been disturbed by FDA's report of adverse effects of oral hypoglycemic agents. Following is an abstract of a January 1, 1971 release by this committee:

Uncritical and premature recommendations of the Food and Drug Administration regarding the treatment of diabetes mellitus are deplored. This controversy arose following a presentation at the 1970 session of the American Diabetes Association. A group of twelve university centers (the University Group Diabetes Program—UGDP) presented the results of an eight-year study. This study *appeared* to show that administration of a sulfonylurea drug (tolbutamide) to mild adult-onset diabetics led to a greater death rate from cardiovascular disease than was found in three other groups treated with diet alone, or with insulin.

In October, a Food and Drug Administration *Current Drug Information Bulletin* was sent to all physicians in the United States. This bulletin contained far-reaching implications regarding the future treatment of diabetics. Portions of the FDA statement may greatly compromise the freedom of the physician to prescribe for his patients. Indeed, the Food and Drug Administration recommends that Orinase (tolbutamide), Dymelor (acetohexamide), Diabinese (chlorpropamide), and Tolinase (tolazamide) be limited to patients with symptomatic adult onset nonketotic diabetes mellitus which cannot be adequately controlled by diet or weight loss alone and in whom the addition of insulin is impractical or unacceptable. The oral hypoglycemic agents are not recommended in the treatment of chemical or latent diabetes, in suspected diabetes, or in pre-diabetes, and are contraindicated in patients with ketoacidosis.

The actions of the FDA are based upon this

solitary report by the UGDP. Yet, the absence of any similar observations during vast experience with large numbers of diabetic patients for periods up to 15 years in the use of tolbutamide and other oral hypoglycemic agents prompted re-examination of the UGDP report.

Actually there was no significant difference in over-all mortality among the four treatment groups. Regarding the alleged excess of cardiovascular deaths in patients treated with tolbutamide, the lack of homogeneity of baseline risk factors in the twelve treatment centers invalidates statistical evaluation of the findings. Also, one independent analysis found no significant difference between tolbutamide and placebo groups with respect to cardiovascular deaths.

Spontaneous leveling of the claimed excessive mortality in tolbutamide-treated patients during the last year of the UGDP study suggests that the alleged increase in cardiovascular deaths is *not* due to the administration of the drug. Furthermore, the application of an arbitrary, constant dosage of tolbutamide differs from the customary clinical usage of the drug. The fact that therapy seemed to have little or no effect on maintaining normal blood sugar levels was attributed to the use of the fixed dosage of tolbutamide, which is also the shortest-acting of the sulfonylurea compounds.

Findings such as these made the group feel that the established treatment of diabetes was under significant pressure on the basis of experimental results of dubious validity. The committee felt that, before any further action is taken by regulatory agencies, the raw data should be made available to the scientific community at large.

These FDA recommendations tend to restrict treatment of patients with latent or asymptomatic hyperglycemia who do not respond to diet alone. The committee vigorously opposed the "uncritical and premature recommendations of the FDA based on a single unpublished report of the UGDP, which is

scientifically unacceptable to many specialists in diabetes. This unprecedented interference with the practice of medicine in a controversial area is not only outside the province of a governmental regulatory agency, but it has also damaged the welfare of a million diabetic patients."

The recommendation restricts any and all oral agents in the treatment of diabetes, despite overwhelmingly favorable clinical experiences to the contrary. The therapeutic implications outlined are ambiguous and impossible to fulfill in accordance with established medical practice. The recent FDA recommendations for the treatment of diabetes seriously undermine the progress made on behalf of the diabetic through years of hard work and education. Diabetics and their families are confused, anxious, and uncertain of their physician's ability to guide their treatment. Progress in employment and insurance status will in many instances be pushed back a number of years by the enforced use of insulin treatment. The practitioner has had no basis for making his own decisions concerning the validity of the UGDP study but is now (at least, indirectly) forced into the use of principles in diabetic treatment prescribed by the FDA. He is potentially exposed to an unprecedented series of malpractice suits based on any occurrence of cardiovascular problems, which happen with great frequency in all diabetic patients, but which may now be blamed upon the taking of an oral hypoglycemic agent.

The recommendations of the FDA tend to constitute the practice of medicine by specifying the order in which therapeutic programs are to be employed in the treatment of patients. This directive, if taken literally, will also seriously hamper future clinical research in this field. By denying the value of chemical control of the disease the FDA emasculates any programs of diabetes detection as well as all public health measures in this area.

The committee concludes by asking for (1) suitable modifications of the FDA *Drug Information Letter*, (2) reconsideration of pro-

posed revisions of the package inserts demanded of the manufacturers of oral hypoglycemic agents; and (3) independent statistical and clinical analysis of the UGDP study based on raw data so far not available to the scientific community.

Signers of this committee statement included Robert F. Bradley, M.D. of the Joslin Clinic; Henry Dolger, M.D., Professor of Clinical Medicine at Mt. Sinai; Holbrook Seltzer, M.D., Chief of Endocrinology at the Southwestern Medical School in Dallas; John O'Sullivan, M.D., Chief of the Diabetes Section in the U.S. Public Health Service in Boston; and Peter Forsham, M.D., Director of Metabolic Research at the University of California.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during January 1971:

	1971 January	1970 January
Aseptic Meningitis	20	13
Primary Encephalitis	3	2
Hepatitis: Total	502	253
Infectious	109	201
Serum	93	52
Malaria: Total	14	17
Military	4	13
Civilian	10	4
Meningococcal Meningitis	2	7
Mumps	314	337
German Measles	22	70
Measles	14	305
Salmonella	73	47
Shigella	40	35

Salmonellosis and Pet Turtles

A recognized source of salmonellosis, particularly for children, is the little green pet turtle. It differs basically from most sources of infection in that the organism is transmitted by contamination of the child's hands rather than by direct consumption in a food item, as is the case for the usual sources such as poultry and non-fat dried milk powder. This, plus the fact that turtles are unlikely to cause a large outbreak, have contributed to the nonchalance with which they are permitted to contribute to the annual toll of salmonella infections.

During 1970 six cases of salmonellosis in New Jersey were shown in the laboratory to have been related to turtles. There were many more instances where turtles were associated with cases but were not cultured. Patients and their turtles were shown to harbor such serotypes as *S. java*, *S. litchfield*, *S. enteritidis*, and *S. typhimurium* var. *copenhagen*. Other serotypes, including *S. newport*, *S. javiana*, and *S. braenderup* were also isolated from turtles last year. The six confirmed cases were children ranging from three weeks to five years old. Most required hospitalization, usually ten days or longer.

These findings have intensified interest in pet turtles as a source of salmonellosis. Consideration should be given to this possible source, particularly when children become infected. Culturing tank water and turtles is a reasonable procedure whenever this relationship is found to exist.

Influenza

In contrast to a virtual absence of influenza activity in New Jersey during the first half of the winter, local outbreaks of influenza-like illness have occurred throughout the State since the latter part of January. Influenza Type B has been confirmed by the New Jersey State Virology Laboratory. Many municipalities have reported high rates of school absenteeism, ranging between 15 and 30 per cent. The outbreaks have been characterized by an abrupt onset with a rapid rise to peak absenteeism. Primarily affected are children and teenagers.

The symptoms most frequently encountered have been fever, sore throat, headache, retro-orbital pain, cough, chills, and myalgias. Gastrointestinal symptoms have been infrequently reported. The illness has been generally mild and of short duration, in contrast to that observed in influenza A² Hong Kong outbreaks of the past two winters. Most adults have immunity to influenza Type B because of prior infection in childhood. For this reason widespread industrial absenteeism is not anticipated.

The Cautious Advice Giver

We are being frightened these days by the fear that we may be sued for giving advice. Well, this is not a 1971 phobia, as witnessed by this "resolution" written in 1955.

Whereas, it has come to my knowledge that Mr. Jones has expressed a wish for a hot tub bath; and

Whereas, he has requested the services of a trained nurse who is an employee of the Community Service Society at the time of this operation; and

Whereas, the rules of this Society demand an order from a Doctor of Medicine authorizing this particular service; and

Whereas, I have been asked by Mr. Jones for this authorization but only through an intermediary; and

Whereas, I have not seen Mr. Jones professionally since the ninth of February, ult.; and

Whereas, I did see and talk with him in a store on Main Street; and

Whereas, it is generally conceded that the bath room of a private house is a place of great danger.

Be It Resolved that in view of the fact that I saw and talked with Mr. Jones in a store on a street some distance from his place of abode, I feel that I can give him the authorization requested, i.e., to have a hot tub bath with the help of the experienced professional attendant mentioned above—without further physical examination. However, it is to be definitely understood that (a) this bath is taken voluntarily by him; (b) no undue force shall be used by the attendant; and (c) the patient shall be allowed the privilege of determining the temperature of the water used, the kind of soap, and the size and nature of the towel for the purpose of drying the body. It is also to be understood that in case of any

litigation following this operation I am to be in no way classed as "an accessory before the fact."

(signed) E. F. Hird, M.D.

P.S. I hope that this will meet with the requirements deemed necessary for your records.

New Support For Eye Test Frames

William H. Brown, M.D., a member of our Union County Medical Society, has just received U.S. Patent 3,531,187 for a support for eye test frames. Dr. Brown explains the background as follows:

Many ophthalmologists, refracting the patient, hear a complaint about the uncomfortable feeling produced by the weight of the trial frames. The young child will frequently complain and resist, while adults cooperate but complain. And, indeed, my ex-

perience has been that the patient, young or old, does have some rough sailing while retinoscopy is being performed. Then, he is further tested to determine if the previous findings are correct. During all of this time, the patient is enduring the weight of the trial frames. I have concluded that the weight of the frames is the basic problem and this challenge became the reason for my invention, Patent 3,531,187, issued September 29, 1970, by the U.S. Patent office.

The "Eye Test Frame Support" is composed of a circular headband, frontal strap, posterior strap, lift strap, lift loop, adjustment loop, and a hook for holding the lift loop.

The prime advantage in using the "Eye Test Frame Support" is the removal of pressure of trial frames on the bridge of the nose and the ears. It allows the trial frame to remain in proper position during refraction. Less time is required to do the refraction, problems or no problems. The lift can be contracted or expanded in all directions to fit the size of the head. It is light in weight, made of a soft fabric, and can be fitted on the head in two minutes.

ANNOUNCEMENTS

Children Need People

On Wednesday morning, March 17, 1971, a meeting will be held at The Manor, Prospect Avenue, West Orange, on the theme, "Children Need Many People." Principal speaker is Marita Kenna, M.D., one of the few psychiatrists certified both by the American Board of Pediatrics and the American Board of Psychiatry and Neurology. Dr. Kenna is Assistant Professor of Psychiatry and Professor of Pediatrics at the University of Pittsburgh. The symposium starts promptly at 9:30 a.m. The discussion is expected to cover both morning and afternoon sessions. The sponsoring organization is the New Jersey Society of Dentistry in Children. The \$10 reg-

istration fee includes coffee break, luncheon, and tips. For reservation, write to Edward Stillwell, D.D.S., Arcade Building, Glen Ridge, New Jersey 07028.

Clinical Application of Basic Sciences

The Burlington County Memorial Hospital series on clinical application of the basic sciences has arranged the following programs for April:

- April 1 The Prediabetic Syndrome
- April 8 Diabetes Mellitus: Recent Advances
- April 15 Management of Exogenous Obesity
- April 22 Management of Hypercalcemia
- April 29 Interservice Seminar

All sessions are held in the Common Room of the T. J. Summey Building at the hospital and convene promptly at 3:30. One and a half credits are given by the American Academy of General Practice. For further information, write to the Department of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Obstetricians And Gynecologists Meet In May

The Nineteenth Annual Clinical Meeting of the American College of Obstetricians and Gynecologists will be held in San Francisco May 3 to 6, 1971. Central themes of this session will be perinatology, pelvic infections, and diseases of the vulva. Non-Fellows may register to attend both the meeting and the postgraduate courses which precede the meeting on May 1 and 2. For registration or information, write to Donald F. Richardson, 79 West Monroe Street, Chicago, Illinois 60603.

Problems In Pediatrics

A graduate course on "Difficult Problems in Pediatrics" will be held at the New York Hospital-Cornell Medical Center, New York, on May 6-7, 1971. This is accepted by the American Academy of General Practice for 12 hours of elective credit. Fee is \$75.00. For more information, write to the New York Hospital, 525 East 68th Street, Room N-834, New York 10021.

Contact Lens Symposium

The annual "Contact Lens Symposium" will be held at the New York Eye and Ear Infirmary, 310 East 14th Street, on Saturday, May 8, 1971. This year's program will concentrate on post-fitting problems with soft and hard contacts. Registration fee is \$50, which includes a gourmet luncheon. For a timetable and more details, write to Registrar, Graduate Institute, Eye and Ear Infirmary, 310 East 14th Street, New York 10003.

Cancer Training Program AT CMDNJN

A three year cancer training grant has been awarded by the U.S. Public Health Service to Dr. Bernard J. Koven, Assistant Professor of Clinical Medicine and Acting Director of the Oncology Division, and Dr. Benjamin F. Rush, Jr., Professor of Surgery of the College of Medicine and Dentistry of New Jersey at Newark.

The cancer program will offer cooperative clinical programs in the detection, diagnosis, treatment, and prevention of cancer. The program is directed to the pre-doctoral student, post-doctoral student in residency training, and the physician in the community.

Medical Students' Summer Programs will make possible four fellowships for medical students to spend summers in research laboratories or doing clinical investigation dealing with problems relating to cancer. Students will participate in a Student Community Cancer Program, working with problems related to cancer in the inner city. Opportunity will be open for selected medical students to take a leave from school for a one year period. These oncology scholars will take special courses to prepare them for a career in clinical or laboratory cancer work.

Seminars will be offered periodically for community physicians seeking additional knowledge in the treatment of cancer. Lectures by outside specialists will be presented, providing specialized knowledge to pre- and post-doctoral students and to community physicians. Post-doctoral oncology fellowships will also be available.

Book Available On Biologic Rhythms

For \$1.75 you can get a copy of *Biological Rhythms in Psychiatry and Medicine*. Write to the Government Printing Office, Washington, D.C. 20203, and ask for NCMHI publication No. 2088. This work is a research report issued by the National Institute of Mental Health.

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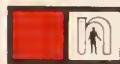
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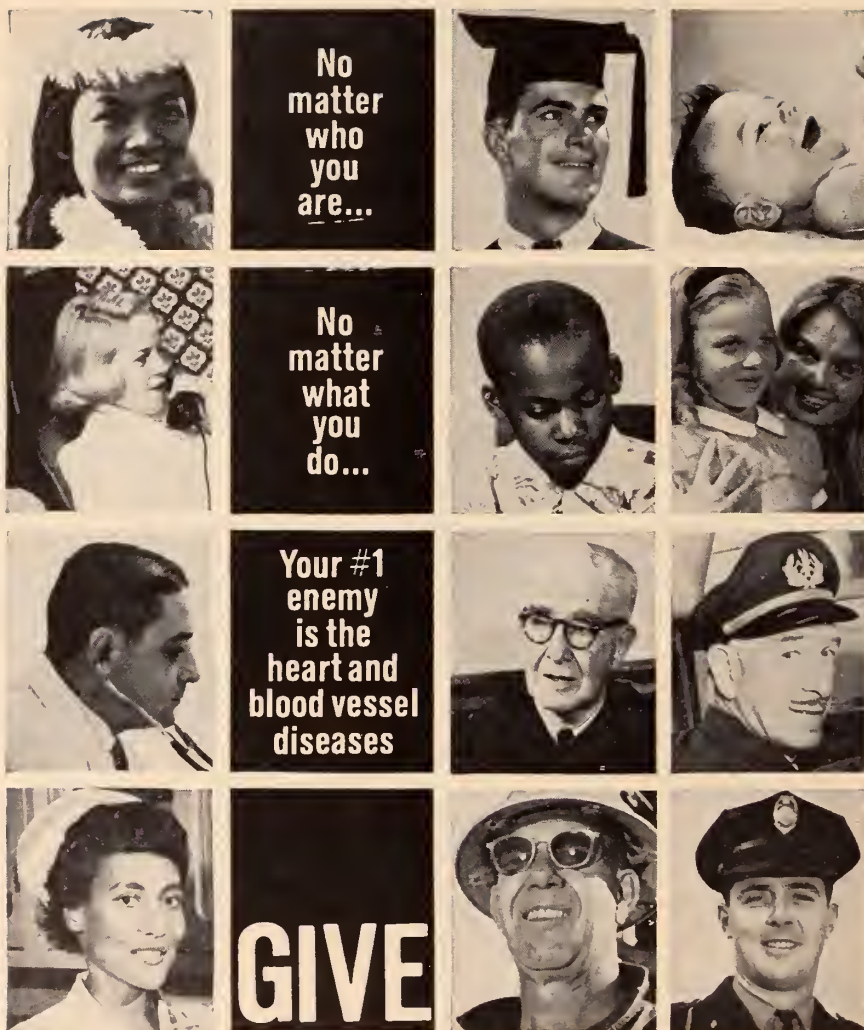
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LETTERS TO THE JOURNAL

In Favor of Technicians

January 12, 1971

Dear Sir:

After reading my paper on page 13 of the *January Journal*, some have asked me if my skepticism about "physicians' assistants" extended to medical technicians. The answer is "not at all." As chief of surgical services in the Tilton and 15th General Hospitals during World War II, I witnessed at close hand the contribution of medical corpsmen in x-ray, operating rooms, the wards, and in the emergency departments. A technician can be of inestimable value to any medical practitioner today, if he can take an electrocardiogram, an x-ray, or a blood or urine analysis. He can, if properly trained, give excellent service and save the physician much time, enabling him to see that many more patients.

(signed) Henry A. Brodtkin, M.D.

Deploras Medical Testimony

January 14, 1971

Dear Sir:

I was wondering whether other physicians have become as concerned as I have toward the role we have been forced to play by the legal system, especially in workman's compensation and in personal liability cases. There are "defendant's doctors" and "plaintiff's doctors." Lawyers send their patients to a doctor who will run up a big bill, give a high estimate of disability, find cause for permanent injury, and give friendly testimony. Attorneys for the insurance company refer patients to physicians who will find little or no disability, suggest that the patient is malingering, and

find no reason for the continued complaints of pain and discomfort. In a compensation court, the insurance company doctor cannot state his true estimate of a disability because he knows that the plaintiff's doctor will present an unusually high figure, and that the judge, in his Solomon-like wisdom, will find an average. The adversary system of law has produced an adversary system of medicine, creating two dishonest physicians in the process.

Although physicians may disagree upon their findings, it is outrageous that we have been prostituted by the legal profession into becoming adversaries, with knee-jerk response to a situation. But when two people constantly disagree in a predictable fashion, damage to the integrity of each must be assumed. The legal profession performs a disservice for its clients by referring them to physicians who may not be best suited to treat their malady, but who are interested in prolonging treatment and maintaining disability. The height of disregard for a patient's welfare (in my practice) has been the advise of an attorney to a fully rehabilitated paraplegic patient of mine not to seek work until his case was settled. The implications of this bad advice should be obvious to anyone who has dealt with these fragile human beings.

I do not purport to know how the physician can deal appropriately with those parties who are seeking different ends than he. I do believe that we have made a mistake in allowing ourselves to be drawn into an adversary position. Perhaps any doctor who gives more than 60 per cent of his testimony for either side in a given year, should be disqualified.

More desirable, would be an impartial medical panel, but this is apparently an unworkable concept. Patients obviously need expert medical testimony for their legitimate claims. But a system must be devised to protect the physician as an individual, and the profession as a whole, from appearing to be partisans or the final result will be loss of self-respect and loss of respect for the profession.

I would be interested in hearing from readers who have thoughts on this matter.

(signed) Robert A. Goldstone, M.D.

Dr. Goldstone has a point, though some of his language seems a bit abrasive. Everyone has the right to have witnesses heard on his behalf, and any plan for a dispositive "impartial" panel would, in effect, eradicate that right. So would the plan to disbar doctors who testify six out of ten times for one side. The doctor who refuses to testify on behalf of his own patient may be making life easier for himself, but he is also depriving the patient of something he urgently needs. It is really not the lawyer's function to "refer the client to the physician best suited to treat him." That is his family physician's responsibility. *The Journal* welcomes views on this matter from other readers. —Henry A. Davidson, M.D.

Bring the Physiatrist in Early

January 18, 1971

Dear Sir:

The article, "Medical Problems in Stroke Patients," in *The Journal* of The Medical Society of New Jersey, page 21 of the January 1971 issue, reviews some of the medical problems which might complicate the course of the stroke patient. Unfortunately, the article makes some implications which, if not clarified, might well lead to certain other iatrogenic complications. The following statements are somewhat out of context, but contain the implication:

"Special attention must be given to the patient's disability after discharge from the hospital. This involves

physiotherapy, rehabilitation, emotional and psychological support, plus family education."

The inference drawn from the above is that the disability gets attention after discharge. Under no circumstances should this problem be left so long. It should be unnecessary to say that attention to the patient's disability begins upon admission to the hospital, when proper positioning, range of motion, etc. should be instituted to prevent contractures and deformities which certainly will otherwise occur. These are iatrogenic complications of stroke, and are really inexcusable today. Certainly, further efforts in rehabilitation should be instituted prior to discharge in an attempt to realize the maximum degree of recovery of function.

There is little question that a neurologist should be intimately concerned with the management of the stroke patient. I submit, however, that there is another discipline which should be represented—physical medicine and rehabilitation. This specialty (the American Board was established in 1947) has long been concerned with the management of the residuals of stroke to minimize the disability of the patient. I suggest that the management of the stroke patient is probably best approached by a medical and paramedical team, in which the multi-disciplinary approach will result in the most favorable outcome for the patient who has suffered a stroke.

(Signed) Percy L. Miller, M.D.

OBITUARIES

Dr. William N. Barbarito

One of Hudson County's leading surgeons, William N. Barbarito, M.D., died on December 12, 1970, at the age of 75. He was a Bellevue graduate, class of 1920. He was affiliated with both the Christ Hospital and the

Fairmount Hospital in Jersey City, eventually becoming senior surgeon at both. Dr. Barbarito was a Fellow of the American College of Surgeons.

Dr. Robert W. Buchanan

One of our state's leading surgeons, Robert W. Buchanan, M.D., died on January 12, 1971. Most of his professional life Dr.

Buchanan had been identified as a clinical surgeon and, indeed, had been a senior attending surgeon at Overlook Hospital in Summit. Always interested in surgical research, he joined Ciba Pharmaceutical Corporation as a senior research associate. He was a Fellow of the American College of Surgeons and was a 1939 graduate of the College of Physicians and Surgeons of Columbia University. Dr. Buchanan was only 58 years old at the time of his death.

Dr. Horace J. Ettinger

One of our state's most colorful physicians, Horace Jacques Ettinger, M. D., died on December 11, 1970. He was a 1908 graduate of the Medical School of the University of Zurich in Switzerland. After interning in Lausanne, he organized and owned a small hospital in Paris. In 1939, he served in the medical corps of the Army of the Republic of France and on being demobilized, early in 1944, he came to the United States. Though 51 years old at that time, Dr. Ettinger passed the New York State Board examination and, for five years, did general practice in that city. He then came to Vineland, New Jersey, and did general practice there, serving on the staff of the Community Hospital in Elmer.

Dr. Vincent Giacalone

Announcement has been made of the death on January 3, 1971 of Vincent Giacalone, M.D. Dr. Giacalone was born in Italy in 1880 but came to this country in his youth and received his M.D. at Fordham in 1915. He did graduate work in surgery and specialized in that field, eventually becoming chief of surgery at the Newcomb Hospital in Vineland. Dr. Giacalone was active in the affairs of the Cumberland County Medical Society and the New Jersey Academy of Medicine.

Dr. Horace J. Graffini

One of Bergen County's best-known obstetricians and gynecologists, Horace J. Graffini,

M.D., died on December 30, 1970. He was on the staff of the Bergen Pines and Englewood Hospitals. Dr. Graffini was one of the founders of the American College of Obstetrics and Gynecology. He was graduated from the Medical School of the University of Rome in 1942 and was 55 years old at the time of his death.

Dr. Melvin A. Greer

Born in 1909, Melvin A. Greer, M.D., was one of the pioneers in the development of oncology as a major medical specialty. He was largely responsible for the creation of the well-known tumor clinic at the East Orange General Hospital, and he served as director of that clinic and chief of oncology at the hospital for several decades. In World War II, he was a major in the medical corps of the Army of the United States. He was, especially prior to World War II, active in the affairs of our Essex County Medical Society. Dr. Greer died on December 17, 1970, at the age of 61.

Dr. Warren G. Kauder

At the untimely age of 54, Warren G. Kauder, M.D., died on January 4, 1971. He was a 1942 graduate of the Medical School of the University of Pennsylvania and had postgraduate training in surgery. He eventually limited his practice to this field and became senior attending surgeon at Doctor's Hospital in Newark, and associate surgeon at Beth Israel and Saint James Hospitals in that city. Dr. Kauder was board certified in his specialty.

Dr. Samuel Kleiner

At the age of 78, Samuel Kleiner, M.D., died on November 24, 1970. He had been on the staff of the Barnert Memorial Hospital in Paterson for many decades and was active in committee work for the Passaic County Medical Society. Dr. Kleiner was in the famous class of 1922 at New York University's medical school. He was, and always remained, a family doctor of the old school.

Dr. Edward W. Mulligan

Born in 1912, Edward W. Mulligan, M.D., died on January 18, 1971. He was an alumnus of Hahnemann, class of 1940. Dr. Mulligan was a general practitioner in Shrewsbury and was a member of our Monmouth County Component Society. He was school physician to the Red Bank Catholic High School and to the public schools of Shrewsbury.

Dr. Bohdan Panchuk

Born in the Ukraine in 1919, Bohdan Panchuk earned his M.D. degree at Erlangen in Germany in 1950. The following year he came to the USA and interned at New York's Columbus Hospital. Interested in surgery, he won appointment as a resident in that field at the Shore Hospital in Brooklyn. In 1956, he came to New Jersey, to the Saint James Hospital in Newark as a Senior House Surgeon. Finally, in 1960, he entered private practice, retaining an affiliation with Saint James Hospital. And then, on November 19, 1970, Dr. Panchuk died at the age of 51.

Dr. Jacob Rosenstein

One of our state's earliest pediatricians, Jacob L. Rosenstein, M.D., died on New Year's Eve at the grand age of 91. He received his M.D. degree at the University of Maryland in 1905. He was an early member of the American Academy of Pediatrics and was one of the first physicians in Hudson County to devote himself exclusively to that specialty. Dr. Rosenstein was affiliated with the Margaret Hague and Christ Hospitals in Jersey City, and with the Bayonne Hospital and Dispensary.

Dr. Gregory E. Sacco

Gregory E. Sacco, M.D., who was born in 1908, died on December 12, 1970, at the age of 62. He was an otolaryngologist, affiliated with the Riverview Hospital in Red Bank. Dr. Sacco was active in the affairs of our

Monmouth County Medical Society. He earned his M.D. degree at Georgetown in 1932.

Dr. Samuel S. Schept

One of Hudson County's senior practitioners, a family doctor of the old school, Samuel S. Schept, M.D., died on December 13, 1970, on the eve of his 80th birthday. Dr. Schept earned his M.D. at the old Long Island College of Medicine in 1914. He was on the staff of the North Hudson Hospital in Weehawken and, for years, was active in committee work for our Hudson County Medical Society. Most of his professional life, Dr. Schept had been serving the people of North Bergen.

Dr. Frances B. Tyson

Frances B. Tyson, M.D., surely one of the most senior physicians in our state, died on January 3, 1971. She was born in 1874, during the administration of President Rutherford B. Hayes, and was 96 years old at the time of her death. She won a Ph.G. on graduation from the Philadelphia College of Pharmacy in 1893 and worked as a pharmacist until she received her M.D. in 1901 from the Women's Medical College. She was selected for one of the coveted General Hospital ("Blockley") internships. Dr. Tyson married in 1909 and gave up practice until the influenza pandemic of 1918 struck our state. She returned to private practice, moving to Englewood, and served for more than four decades on the staff of the Englewood Hospital. She was school physician for the Englewood Board of Education for thirty years. In 1951 the Federated Women's Clubs selected Dr. Tyson as "Woman of the Year." She was on a television panel presentation in 1956—a program called "Life Begins at 80." (She was 82 at the time.) Dr. Tyson was well-known for work with children, although she always considered herself a family physician, not a pediatrician. For this work with children she received the Freedom Foundation Award. In 1957 she was a laureate of our Society's Golden Merit Award.

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A family doctor looks at new developments in the pharmaceutical industry. And he speculates on the future.

When I look back at some of my old records, I'm constantly reminded of the changes that have come about in medicine just during the past twenty-five years. Some of the diseases I treated and prayed over in the '40's are found mostly in medical history books now.

Thanks to drug research and development, we've made substantial gains in the control of cardiovascular disease, diabetes, malaria, mental illness, strep and staph infections, meningitis and a long list of ailments. It seems like only yesterday when a diagnosis of pneumonia was almost the kiss of death. Now, with modern medical techniques and drug therapy, we can offer some real help.

My records on polio, influenza and measles show an unbelievable trend for the better. New vaccines

have reduced the toll of these age-old threats dramatically. And I see patients in pain from crippling arthritis helped with new medicinals unknown just a few years ago.

I hear questions about the three billion or so dollars spent by the drug industry in research during the past ten years . . . working on new and better drug products. It does seem like quite a bit of money to spend, and I realize some of it goes into dead ends. That's the problem with research, any research . . . you often don't know where you're going until you get there. I want all the tools I can get to help my patients. I want more drugs and more effective drugs. If they mean less pain, longer lives and more productive careers for those I treat . . . well, that's what really counts.

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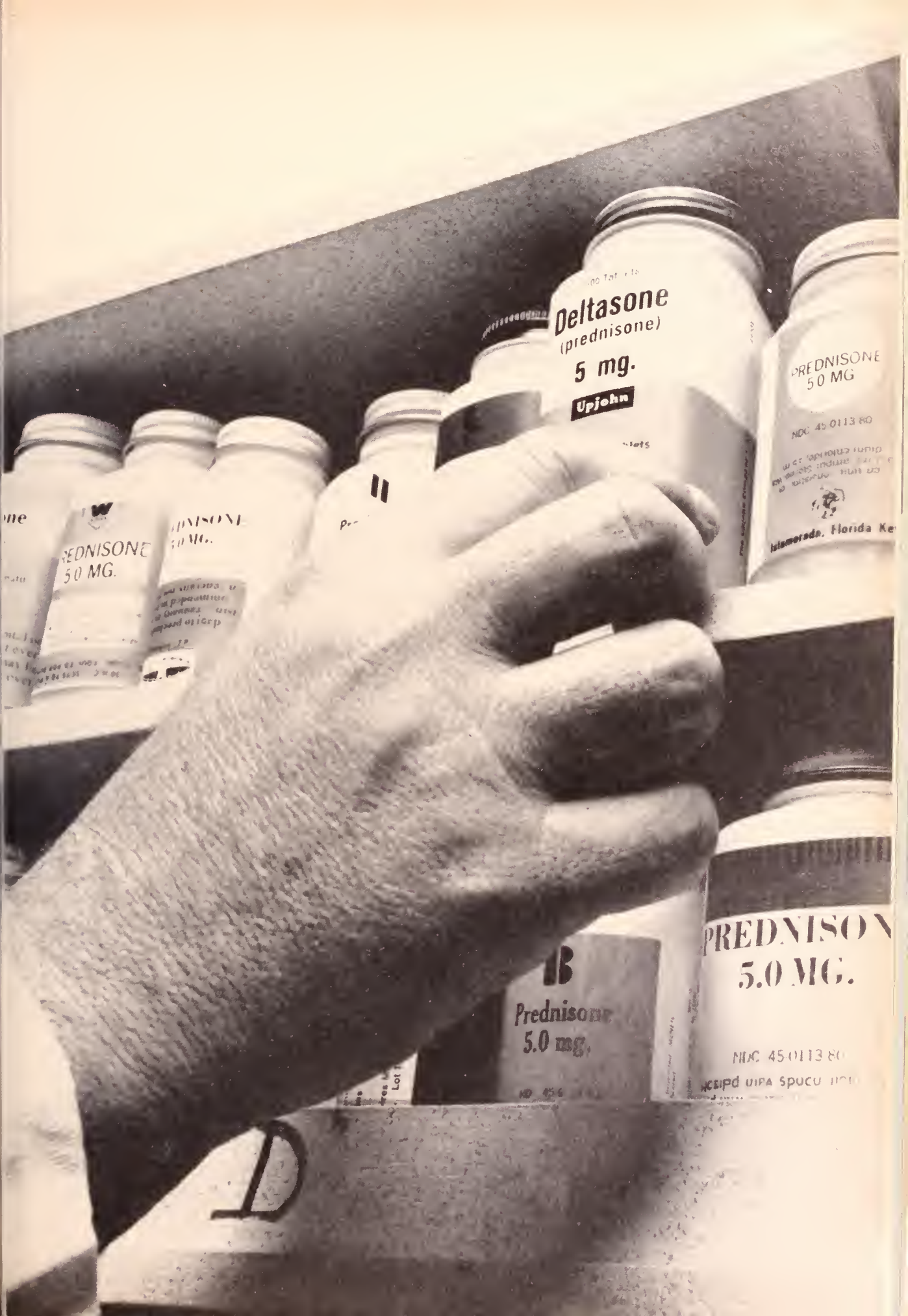
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Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance

doses of Deltasone (prednisone); however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9- α -fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoid during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis an ulcer regimen and antacid are highly recommended. Take X-ray in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery, severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fracture; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

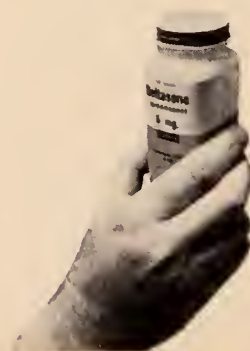
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MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1971

March

- 10 Muhlenberg Hospital
- 17, 24 Plainfield
Neurology
- 10 New Jersey Allergy Society
- 17, 24 Holy Name Hospital, Teaneck
Allergic Dermatitis
- 10, 17, Columbus Hospital
- 24, 31 Hospital Annex, Newark
Simplified ECG for the Family Physician
- 10 Academy of Medicine of New Jersey
Overlook Hospital, Summit
Respiratory Failure
- 11 Burlington County Memorial Hospital
Mount Holly
Sexual Problems Seen in Office Practice
- 16 Associated Eye Residencies of New Jersey
Eye and Ear Infirmary, Newark
Corneal Problems with Contact Lenses
- 16 Academy of Medicine of New Jersey
Overlook Hospital, Summit
Renal Failure
- 16 Academy of Medicine of New Jersey
Burlington County Memorial Hospital
Mount Holly
Generation Gap in Medicine
- 17 Academy of Medicine of New Jersey
Atlantic City Hospital
Emergency Room Care
- 17 Academy of Medicine of New Jersey
Cornell School of Medicine, New York
Cardiac Drugs
- 18 Morris County Medical Society
- 18 Gloucester County Medical Society
- 18 Burlington County Memorial Hospital
Mount Holly
Biochemical Parameters of Aging

- 24 Academy of Medicine of New Jersey
Dental Section
Veterans Hospital, East Orange
Symposium on Intact Dentition
- 24 Academy of Medicine of New Jersey
Massachusetts General Hospital, Boston
Gastrointestinal Disease
- 25 Burlington County Memorial Hospital
Mount Holly
Hyperlipoproteinemias
- 25 Sandoz Medical Lectures
Sandoz Auditorium, Hanover
Problems of Drug Interactions
- 25 Academy of Medicine of New Jersey
and Radiological Society of New Jersey
Orange Memorial Hospital, Orange
- 29 Cape May County Society
- 31 Academy of Medicine of New Jersey
Cornell Medical Center, New York
Heart Surgery
- 31 Academy of Medicine of New Jersey
Hoffmann-LaRoche, Nutley
Symposium—Controversy in Medicine

April

- 1 Burlington County Memorial Hospital
Mount Holly
Pre-diabetic Syndrome
- 5 Academy of Medicine of New Jersey
Greenville Hospital, Jersey City
Emergency Room Care
- 6 Hudson County Medical Society
- 7 Academy of Medicine of New Jersey
Saint Barnabas Medical Center
Livingston
Symposium on Ecology
- 7 New Jersey Allergy Society
Holy Name Hospital, Teaneck
Allergic Dermatitis

- | | | | |
|------------------|---|----------------|---|
| 7
and
14 | Academy of Medicine of New Jersey
Holy Name Hospital, Teaneck
Uremia | 22 | Academy of Medicine of New Jersey
and Radiological Society of New Jersey
Orange Memorial Hospital, Orange |
| 7, 14,
21, 28 | Columbus Hospital
Hospital Annex, Newark
Simplified ECG for the Family Physician | 28 | Academy of Medicine of New Jersey
St. Barnabas Medical Center
Livingston
Pre and Post Operative Care |
| 8 | Burlington County Memorial Hospital
Mount Holly
Recent Advances in Diabetes Mellitus | 28 | Academy of Medicine of New Jersey
School of Nursing Auditorium
Leukemia as Human Tumor Model |
| 8 | Saint Barnabas Medical Center
Livingston
Irradiation Therapy | 29 | Burlington County Memorial Hospital
Mount Holly
Interservice Seminar |
| 13 | Cumberland County Medical Society | | |
| 13 | Bergen County Medical Society | May | |
| 13 | Middlesex County Medical Society | 4 | Academy of Medicine of New Jersey
Morristown Memorial Hospital
Morristown
Diagnosis and Treatment of Shock |
| 14 | TB-Respiratory Disease Association of
Southern New Jersey | 4 | Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Drug Addiction |
| 14 | Academy of Medicine of New Jersey
Runnells Hospital, Berkeley Heights
Difficult Diabetic Patient | 5 | Camden County Medical Society
Tavistock Country Club
Haddonfield |
| 15 | Gloucester County Medical Society | 5, 12, | Columbus Hospital |
| 15 | Morris County Medical Society | 19 | Hospital Annex, Newark
Simplified ECG for the Family Physician |
| 15 | Burlington County Memorial Hospital
Mount Holly
Management of Exogenous Obesity | 6 | Saint Barnabas Medical Center
Livingston
Familial Toxemia |
| 20 | Warren County Medical Society | 6 | Burlington County Memorial Hospital
Mount Holly
Drug Abuse |
| 20 | Academy of Medicine of New Jersey
Englewood Hospital, Englewood
Leukemia and Lymphoma | 11 | Academy of Medicine of New Jersey
Overlook Hospital, Summit
Diagnosis and Treatment of Shock |
| 20 | Academy of Medicine of New Jersey
Yale—New Haven Medical Center
New Haven, Connecticut
Endocrinology | 13 | Burlington County Memorial Hospital
Mount Holly
Management of Acute Drug Intoxication |
| 21 | Academy of Medicine of New Jersey
Saint Michael's Medical Center, Newark
Cardiovascular Workshop | 15
to
18 | The Medical Society of New Jersey
Haddon Hall, Atlantic City
Annual Meeting |
| 22 | Sandoz Medical Lectures
Sandoz Auditorium, Hanover
The Disturbed Child | 20 | Burlington County Memorial Hospital
Mount Holly
Amniocentesis and Amniocentesis in Preg-
nancy |
| 22 | Burlington County Memorial Hospital
Mount Holly
Hypercalcemia | | |

BOOK REVIEWS

Modern Treatment (Vol. 7, #2): **Treatment of Pyelonephritis**, John H. Moyer, M.D. and Charles D. Swartz, M.D., editors. **Diuretics in the Management of Fluid Retention**, Henry O. Heinemann, M.D., editor. Harper and Row, 1970, New York. Pp. 252. Illustrated. (\$20 by subscription)

Here is a timely review of current thinking in these two specific areas. Because of the significance of the two pressing clinical problems the topics become more relevant particularly in attempting to evaluate the significance of recurrent bacteriuria and how to know when destructive renal parenchymatous disease is present even when no bacteria can be recovered from the urine.

Many of the questions and uncertainties of the management of chronic indolent disease of the urinary tract are explored in depth. In general an oppressive therapeutic approach is advocated. In conclusion the articles contained in this volume are a reasonable guide to physicians treating patients with chronic pyelonephritis.

JOSEPH J. KINNEY, M.D.

Gas Chromatography in Biology and Medicine. Edited by Ruth Porter. Baltimore, Maryland, 1970, Williams and Wilkins. Pp. 213. Illustrated. (\$11.50)

This symposium brought together a distinguished international group of gas chromatographers who presented papers and participated in panel discussions. The published proceedings include material on biological and medical applications and on general trends in gas chromatography.

The present state of the art in columns and detectors and progress in analysis by spectrometric and computer methods are given in carefully selected topics. Most analytical problems in biology and medicine amenable to gas chromatography can be related to the topics covered in that section. Valuable panel discussions of each topic enhance understanding of the problems and frequently speculate on future expectations and possibilities.

The book is informative, clearly written, and well edited. It is valuable to those interested in the present state of gas chromatography as an analytical method and to those who chose to use gas chromatography for analysis in biology and medicine.

EDWARD TOWNLEY

Synopsis of Dermatology (Second Edition). William D. Stewart, M.D., Julius L. Danto, M.D., and Stuart Maddin, M.D. Saint Louis, 1970, Mosby. Pp. 445. Illustrated. (\$13.95)

This synopsis is a substantial contribution to dermatologic education. An updated version of its 1966 predecessor, it contains, in one small volume, a well-balanced, authoritative course in dermatology. The reader is taken step by step through an excellent

introduction to anatomy and physiology, to clinical dermatology, regional diagnoses, and specific diseases. The text is complete, concise, and beautifully illustrated. The formulary is sound.

I would criticize the continued use of mercury in ointments. Also 5 FDU is suggested for Bowen's Disease for erythroplasia, but not mentioned is its valuable place in the therapy of actinic keratoses. In discussing tetracycline use in acne during pregnancy, it appears that "not" has been omitted which makes it seem that the authors favor such use, which I am sure they do not. The excellent chapter on malignant tumors has a statement that basal cell epitheliomata do not occur on the palms and soles. This is contrary to the experience of others.

With these minor exceptions, I consider this a most valuable aid to the student and practitioner.

Benjamin B. Burrill, M.D.

A Physician's Living Thoughts. Carl Thenebe, M.D. New York, 1970, Philosophical Library, Inc. Pp. 163. (\$4.95)

One would expect this little book to appeal to a wide audience spectrum in and out of the field of medicine. The jacket informs us that the thinking doctor should not pass up the chance to absorb and reflect the wisdom and philosophy that have emerged from years of medical practice: fifty years in the case of the author. It sounds as if here one might pick up gems while browsing, against the threat of a moment of idle time.

However, this noble intent has gone astray. Simple observations of everyday occurrences have been phrased in stilted language. Over-simplification of ideas couched in awkward neologisms can make even the religious thought distasteful. A simple statement of the facts herein would not, it is true, have added much to the world's literature, but it would have been a by-product of a life's work that could stand with many others in this field.

JAMES G. FOLEY, M.D.

Breathing (Ciba Foundation). Edited by Ruth Porter. Baltimore, Maryland, 1970, Williams and Wilkins. Pp. 402. Illustrated. (Price not stated)

It is fitting that a symposium celebrating the hundredth anniversary of the discovery of the Hering-Breuer breathing reflex has been published by Ciba with a truly international flavor. The publication includes papers from Great Britain, United States, Finland, Scotland, Russia, and India. A wealth of basic experimental and physiologic data, written in the beautiful prose characterizing British publications, is present. The book begins with interesting historical data. The table of symbols in the beginning is useful and appropriate. Summaries in each section bring together much diversified data for the reader. Each paper examines certain common phenomena and discusses in detailed physiologic terms (with experimental evidence) what workers are accomplishing in this field. Sometimes more questions are raised than answered but an in-depth detailed discussion is present. The "clinical" section at the end is complex and difficult reading. The book concludes with a nice translation of Hering and Breuer's original article describing the discovery of their famous reflex. Here is a valuable addition to the library of the respiratory physiologist and to the specialist in chest diseases.

Ellis P. Singer, M.D.

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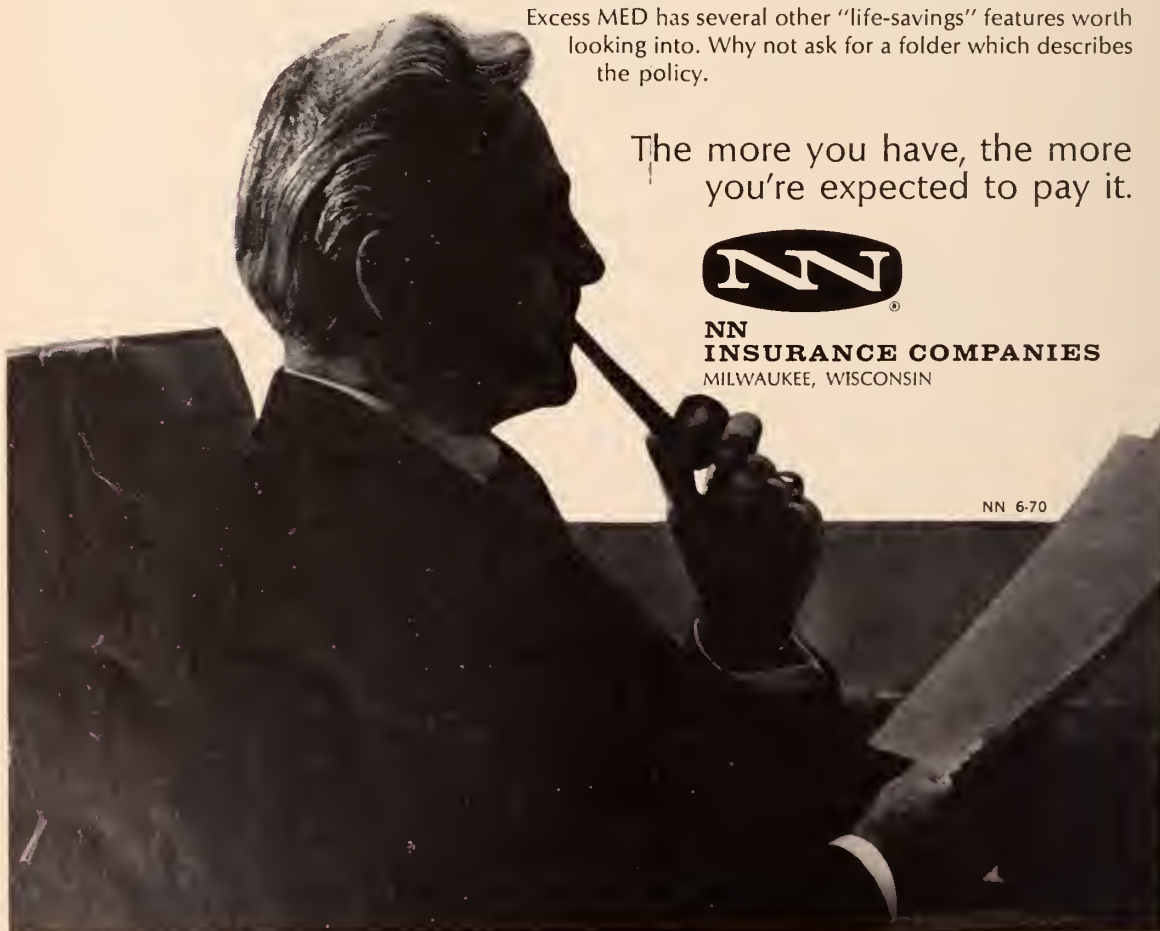
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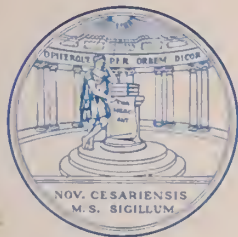
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APRIL, 1971

VOL. 68, NO. 4

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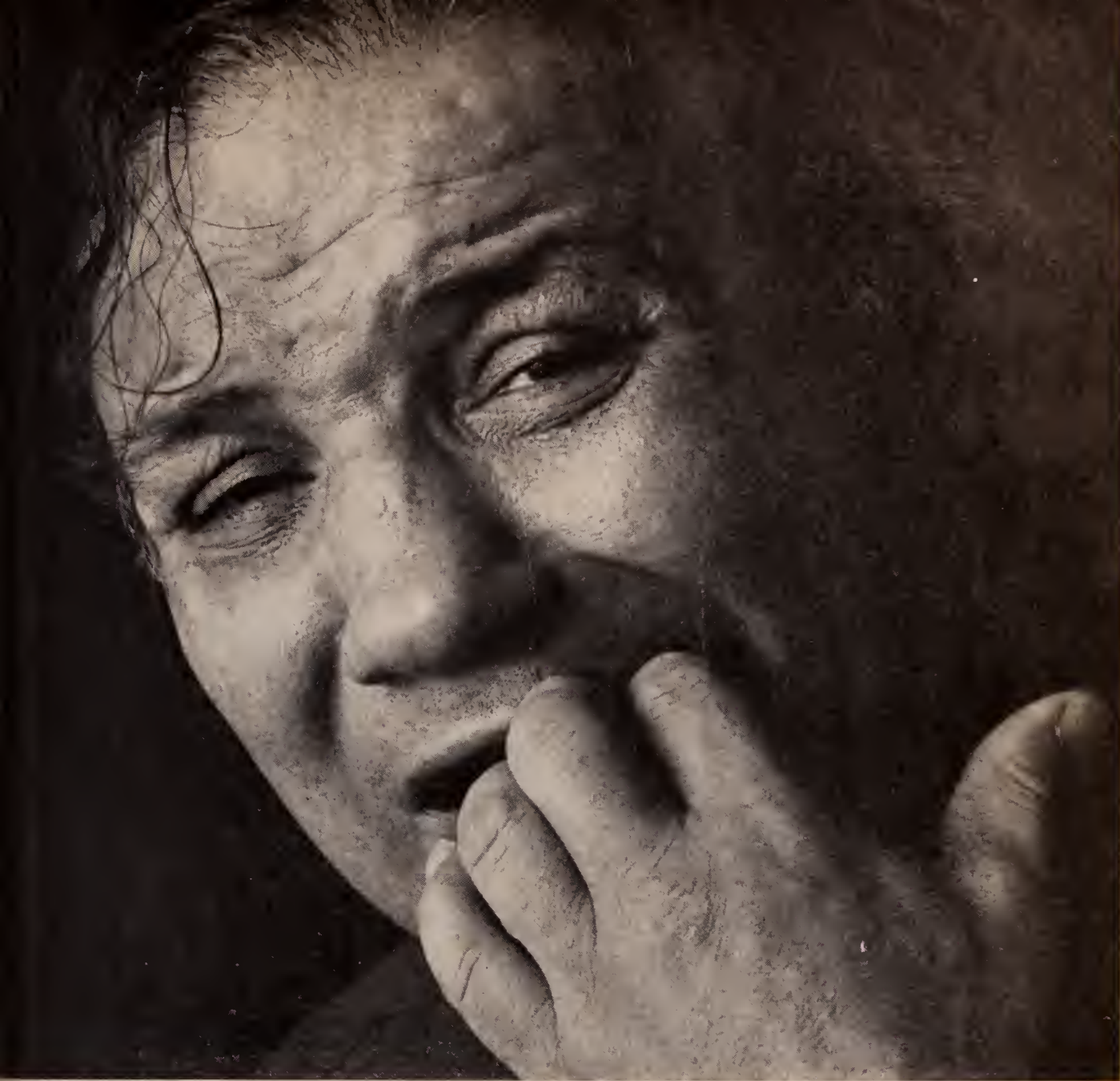
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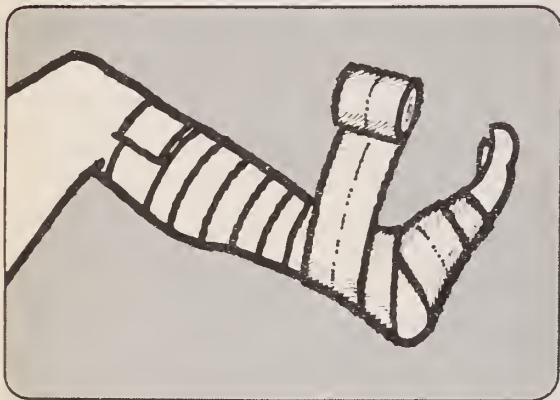
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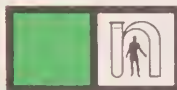
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Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.). TEPANIL One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in mid-evening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-107/4/71/U.S. PATENT NO. 3,001,910



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Prescribing Information — Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and stotic foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



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the night shift of depression... insomnia

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NOTE: Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: Block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. **Anticholinergic:** Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. **Dther:** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. **Withdrawal Symptoms:** Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

For more detailed information, consult your MSD representative or see the *Direction Circular*. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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EDITORIALS

Don't Be An Anti-Exhibitionist!

Exhibitionism is, the psychiatrists tell us, some kind of disease. However, you can be a non-exhibitionist without being an anti-exhibitionist. We refer to the members and guests at the Annual Meeting who don't look at the exhibits. For some reason (and we may have to consult the Section on Psychiatry for an answer) New Jersey doctors and their guests show feebleness of interest in the exhibits—technical, educational, and scientific—than our colleagues in other states. And we have an interest in this strange coldness to the exhibits, an interest that is partly scientific, partly humanitarian, and partly commercial. On the commercial side (to get these sordid financial matters over with) the exhibitors provide a lot of the financial fuel that keeps our Annual Meeting in high gear. And, if they feel that their carefully prepared exhibits are given a cold shoulder, or just a once-over-lightly by our members and guests, they may decide "what's the use?" and then Atlantic City (and your Society's coffers) will be that much barer. Then, too, there are humanitarian reasons. Picture the plight of a poor doctor who has painstakingly prepared an exhibit on the pathophysiology of pulmonary emboli, who eagerly sits at his exhibit, a pile of reprints on one table and a chain of coffee containers on the other, and who waits while the crowds pass him by, with only an occasional visit from the doctor's family. The frustrating effects of this unrewarded vigil must be devastating. So much for the humanitarian reason.

But most important is the educational value of the exhibits. A technical exhibit may be designed, it is true, to promote the sales of second-hand diapers or scythes for the amputation of athlete's foot. However, no exhibitor is going to rent space unless he knows

that his product is of use to the doctors. So you can be sure if it is shown it has been found useful. The scientific exhibits, of course, have direct and unmistakable pedagogic value to all of us—to all, except the few who already know everything about medicine and surgery in all its forms. But unless you belong in that elite category, you are bound to learn something. Anyway, what's your hurry? As you stroll through the exhibit hall, stop and browse at each booth. And register your name too. No matter how many of you look with interest at the exhibit, the people who pay for it will never know unless there is a card or signature to be tallied.

We acknowledge the counter attractions of the boardwalk, and we know that some state societies hold meetings in communities where the exhibit hall is the most interesting place in a dull town. But still, our exhibitors (both technical and scientific) deserve your support, at least in terms of looking and listening. Let's reverse the trend in 1971 and make Atlantic City this May a place for benign voyeurs!

The Overstatement Of Complaints

When a patient presents himself he presumably wants something done. Principally he wants treatment, but maybe he also wants attention in general. It is safe to assume that the one thing he does not want is to be ignored, or airily dismissed. Assume then, that he wants "treatment"—using that word in its broadest sense. And what is the passport to treatment? Symptoms, that's what. So this leads to an unconscious (or sometimes a conscious) overstatement of symptoms. It is probably true that, in general, the pain is not quite as severe, the cough not quite as hacking, the fatigue not quite as wearing as the patient says in his oral description.

If, in the modern fashion, we view the doctor-patient dialogue as a "transaction" (not in the financial but in the emotional sense), we can

see the elements of this "transaction." The doctor isn't sure that the medication he is prescribing, or the physical therapy he is applying, or even the advice he is giving is going to do much good. But he has to do something. The patient, anxious to have something done, plays it safe by overstating his symptoms, just as the doctor plays it safe by doing something. For a physician to say, "go home; I have nothing that will help you" is cruel, disappointing to the patient, and often enough untrue. From the doctor's point of view, this is a confession of powerlessness, and no one wants to be branded as impotent. From the patient's point of view it is a frustrating, maddening experience.

Sometimes indeed, it is as if the patient's emotional need meets the doctor's need. The patient needs to feel he is being cared for, that he has a strong and decisive person to lean on. The physician needs to feel that he is helpful, that he is doing something and that the patient is justified in this dependence.

And also, let it be stated that a doctor's dilemma is produced by *assuming* that the complaints are over-stated. There are, after all, patients who, for reasons that your friendly neighborhood psychiatrist will explain, tend to understate rather than overstate their disabilities. And we aren't really psychic enough to tell what is a particular patient's category. So the pass-word seems to be: assume that the patient is overstating his symptoms; but treat him as if he weren't.

Back To Materia Medica

The nineteenth century medical student had to learn that opium was derived from the dried juice of the sun-ripened capsule of the oriental poppy, *Papaver Somniferum*. Digitalis, of course, came from the thimble-shaped flowers of the foxglove — *Digitalis purpurea*. The very phrase "materia medica" — the "stuff of medicines" — was understood then to mean medical botany. The seal of The Medical Society of New Jersey carries the phrase *Opi-*

ferque per orbem dicor: I am known throughout the world as the bearer of good things. It refers to Apollo's familiarity with the medicinal qualities of plants.

The development of organic chemistry at the turn of the century changed all that. During the past 75 years, most of the advances in pharmacognosy have been in the direction of pharmacologic synthetics — sometimes the chemist's effort to imitate nature, but more often aimed at a new combination of artificially produced drugs with the hope of developing something stronger and safer. Thus, botanical materia medica seems to be taking a back seat. Certainly no American medical student today is expected to know any botany.

The discovery — or, more accurately, the re-discovery — of the pharmacologic value of reserpine suggested that there might be some life in the old plants yet. Today, many pharmaceutical companies have decided to divert some of their research budget into botanical exploration. This is a forward-looking, not a backward-looking, step.

In this respect, we seem to have gone through three phases since Paracelsus became more fashionable than Galen. First, the stage of credulous belief in the claims of any herb collector; then, a phase of botanical nihilism — rejecting all such claims on the theory that any medicinal properties in a plant could be better developed synthetically (the digitalis story, for instance); and now, a skeptical, but not a cynical, attitude of suspended judgment toward the claims of curative properties made on behalf of plants by native tribesmen or even witch doctors. The therapeutic potentials of plants have been known (or at least asserted) since the Sumerian tablet of 2100 B.C. described the medicinal effects of asafetida and thyme. But now the resources of modern biochemical, industrial, and research technics are being applied to them. For all we know — and we cannot afford to laugh it off — a treatment for cancer or hypertension may still be locked up somewhere in Nature's medicine chest. Perhaps *vis medicatrix naturae* may have a double meaning.



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205th ANNUAL MEETING

The Medical Society of New Jersey

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Emanuel M. Satulsky, M.D.
President

James A. Rogers, M.D.
Chairman, Annual Meeting
Committee and Committee
on Scientific Program

Arthur Bernstein, M.D.
Chairman, Committee on
Scientific Exhibits

Marion R. Walton
Convention Manager

May 15-18, 1971
Chalfonte-Haddon Hall
Atlantic City

1971 Annual Meeting

RESUMÉ OF EVENTS

Saturday through Tuesday
May 15 to 18, 1971

Chalfonte-Haddon Hall
Atlantic City

Registration

Saturday, May 15 from 10:00 a.m. to 4:30 p.m.
Sunday and Monday, May 16 and 17, from 9:00 a.m. to 4:30 p.m. Tuesday, May 18 from 9:00 a.m. to noon.

Golden Merit Award

Saturday, May 15 at 1:00 p.m. Honored will be those members of MSNJ who have held the degree of Doctor of Medicine for fifty years. Reception following ceremony.

Motion Picture Theater

Saturday, May 15 at 2 p.m. Sunday and Monday, May 16 and 17 at 10:00 a.m. and at 2:00 p.m. Program arranged and presented through the cooperation of Roche Laboratories, Division of Hoffmann-LaRoche, Inc., Nutley, New Jersey.

House of Delegates

First Session—Saturday, May 15 at 2:30 p.m.

Second Session—Sunday, May 16 at 3:30 p.m. (Election)

Third Session—Tuesday, May 18 at 9:00 a.m.

General Session

Saturday, May 15 at 3:15 p.m.—A review and report on recent developments and the current status of the College of Medicine and Dentistry of New Jersey.

Medical-Surgical Plan

Saturday, May 15 at 4:00 p.m.—Open Discussion Joseph P. Donnelly, M.D., President, MSP, presiding.

Exhibitors' Reception-Buffer-Cabaret

Saturday, May 15 at 6 p.m. A special invitation is extended to members, guests, wives of members and guests, and Auxiliary members to attend a reception and buffet honoring technical exhibitors, followed by entertainment—excerpts from programs previously presented by the Phi Delta Epsilon Players—and dancing. (Tickets at the Registration Desk—\$12 per person).

Special Session on Drug Abuse

Sunday, May 16 at 9:30 a.m.—“The Physician Faces Drug Abuse”—presented in cooperation with the College of Medicine and Dentistry of New Jersey.

Scientific Program

Scientific Sessions:

Sunday, May 16 at 9:30 a.m. and at 1:00 p.m.
Monday, May 17 at 9:30 a.m. and at 2:00 p.m.

Reference Committees

Sunday, May 16 at 11:00 a.m.

(Coffee-Meeting with Chairmen at 10:30 p.m.)

Reception for President-Elect Davis

Sunday, May 16 at 6:00 p.m. Members, guests, wives of members and guests, and Auxiliary members are invited to attend a reception honoring the President-Elect, E. Vernon Davis, M.D. (Admission by badge).

Dinner-Dance

Monday, May 17 at 7:00 p.m. Members, guests, wives of members and guests, and Auxiliary members are invited to attend a dinner-dance in honor of President Satulsky. (Tickets at Registration Desk \$11 per person).

Miscellaneous

Saturday, May 15 at 11:30 a.m.—Luncheon, New Jersey Committee on Trauma, American College of Surgeons

Saturday, May 15 at 1:00 p.m.—Annual Trauma Oration, New Jersey Committee on Trauma, American College of Surgeons

Saturday, May 15 at 7:00 p.m.—Officers' Dinner (By invitation only)

Sunday, May 16 at 12 noon—Luncheon-Meeting, American College of Cardiology

Sunday, May 16 at 12 noon—Luncheon-Meeting, New Jersey Chapter, American College of Chest Physicians

Sunday, May 16 at 12 noon—Luncheon-Meeting, Council, New Jersey Obstetrical and Gynecological Society

Sunday, May 16 at 1:00 p.m.—Luncheon, New Jersey State Society of Anesthesiologists

Sunday, May 16 at 8:00 p.m.—Inaugural Dinner (By invitation only)

Sunday, May 16 at 8:00 p.m.—Dinner, New Jersey Obstetrical and Gynecological Society

Monday, May 17 at 8:00 a.m.—JEMPAC Breakfast

Monday, May 17 at 12 noon—Luncheon-Meeting, New Jersey Allergy Society

Monday, May 17 at 12 noon—Luncheon-Meeting, New Jersey Society of Internal Medicine

Monday, May 17 at 12 noon—Luncheon-Meeting, New Jersey Orthopaedic Society

Monday, May 17 at 12 noon—Luncheon-Meeting, New Jersey Chapter, American Academy of Pediatrics

Monday, May 17 at 12 noon—Luncheon-Meeting, New Jersey Rheumatism Association

Monday, May 17 at 1:00 p.m.—Meeting, New Jersey Chapter, American College of Surgeons

1971 Annual Meeting

DAILY SCHEDULE

Saturday through Tuesday
May 15 to 18, 1971

Chalfonte-Haddon Hall
Atlantic City

Friday, May 14, 1971

4:00 p.m.—Board of Trustees

Saturday, May 15, 1971

10:00 a.m.—Registration Opens
11:30 a.m.—Luncheon: New Jersey Committee on Trauma, American College of Surgeons
12 noon—Exhibits Open
1:00 p.m.—Golden Merit Award Ceremony
Reception for Recipients and Families
1:00 p.m.—Annual Trauma Oration
New Jersey Committee on Trauma
American College of Surgeons
2:00 p.m.—Motion Picture Theater
2:30 p.m.—House of Delegates
3:15 p.m.—General Session
4:00 p.m.—Open Discussion on Medical-Surgical Plan
4:30 p.m.—Nominating Committee
6:00 p.m.—Reception-Buffer-Cabaret for Technical Exhibitors
(Invitation is extended to members, official guests, their wives, and Auxiliary members—tickets at Registration Desk, \$12 per person.)
7:00 p.m.—Officers' Dinner
(By invitation only)

Sunday, May 16, 1971

9:00 a.m.—Registration and Exhibits Open
9:30 a.m.—Scientific Sessions:
Chest Diseases
Drug Abuse
Obstetrics and Gynecology (all day)
Otolaryngology
10:00 a.m.—Motion Picture Theater
10:30 a.m.—Coffee Meeting with Reference Committee Chairmen
11:00 a.m.—Reference Committee Meetings
11:30 a.m.—Luncheon-Meeting:
American College of Cardiology
12 noon—Luncheon-Meetings:
New Jersey Chapter, American College of Chest Physicians
Council, New Jersey Obstetrical and Gynecological Society
12:30 p.m.—Luncheon:
New Jersey State Society of Anesthesiologists
1:00 p.m.—Scientific Sessions:
Anesthesiology
Obstetrics and Gynecology, (cont'd.)
Cardiovascular Diseases
Psychiatry and Neurology

2:00 p.m.—Motion Picture Theater
3:30 p.m.—House of Delegates (election)
Addresses by President Satulsky and
and President-Elect Davis
6:00 p.m.—Reception Honoring President-Elect Davis
(All members, official guests, their wives, and Auxiliary members are cordially invited to attend—admission by badge.)
8:00 p.m.—Inaugural Dinner (by invitation only)
8:00 p.m.—Dinner: New Jersey Obstetrical and Gynecological Society (invitation only)

Monday, May 17, 1971

8:00 a.m.—JEMPAC Breakfast
9:00 a.m.—Registration and Exhibits Open
9:30 a.m.—Scientific Sessions:
Allergy, Medicine
Clinical Pathology, Dermatology
Gastroenterology and Proctology
General Practice, Pediatrics
Orthopedic Surgery
Radiology, Rheumatism
Surgery
Urology
10:00 a.m.—Motion Picture Theater
12 noon—Luncheon Meetings:
New Jersey Allergy Society
New Jersey Society of Internal Medicine
New Jersey Orthopaedic Society
New Jersey Chapter,
American Academy of Pediatrics
New Jersey Rheumatism Association
1:00 p.m.—Meeting, New Jersey Chapter, American College of Surgeons
2:00 p.m.—Scientific Sessions:
Ophthalmology
Plastic and Reconstructive Surgery
2:00 p.m.—Motion Picture Theater
5:00 p.m.—Exhibits Close
7:00 p.m.—Annual Dinner Dance
(All members, official guests and their wives, and Auxiliary members are cordially invited to attend—tickets at Registration Desk, \$11 per person.)

Tuesday, May 18, 1971

9:00 a.m.—Registration Opens
9:00 a.m.—House of Delegates
12 noon—Registration Closes

Wednesday, May 19, 1971

8:30 a.m.—Board of Trustees

—1971 Annual Meeting—

GOLDEN MERIT AWARDS

Saturday, May 15

1:00 p.m.

Presiding

Emanuel M. Satulsky, M.D., President

Master of Ceremonies

John J. Crosby, Jr., M.D., Chairman, Council on Public Relations

Marshals

Presidents of Component Societies whose members are receiving awards

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Recipients For 1971

County	Member	County	Member
Bergen	Frederick George Dilger, M.D. Edgar M. Tennis, M.D. Stuart Ward Vanderbeek, M.D. Abram Weiss, M.D.*	Hudson	Edgar Allen Poe Peters, M.D. Benjamin E. Shook, M.D. Julius Siegler, M.D. Anthony Joseph Watman, M.D. William Eero Wiren, M.D.
Burlington	Charles Frederick Kutteroff, M.D. William C. V. Wells, M.D.	Mercer	Francis Edward Proctor, M.D.
Cape May	Victor I. Barrows, M.D.	Middlesex	Carmine Falcone, M.D.
Cumberland	Leslie Edwin Myatt, M.D.	Monmouth	Frank Joseph Altschul, M.D. C. Byron Blaisdell, M.D. Victor Knapp, M.D. Robert Abbe MacKenzie, M.D. Raul Pietri, M.D.
Essex	Zachary Davis Boris Balson, M.D. Meyer Weinstock Bergman, M.D. Joseph I. Echikson, M.D. Howard Malcolm Freas, M.D. Livingston Spraker Hinckley, M.D. William Rhys Jones, M.D. James Victor Lyons, M.D. Clymont MacArthur, M.D. Alfred Meurlin, M.D. Vincent Napoliello, M.D. Joseph Clarence Spallone, M.D. Robert George Stewart, M.D. Max Gordon Straus, M.D.	Morris	Anthony Ambrose, M.D. Joseph Donovan, M.D. Julian Francis Johnston, M.D. Wayne Willard Hall, M.D. S. Bell Lucent, M.D. Philip H. Simon, M.D. Moses Carl Sucoff, M.D. Emanuel Glaser, M.D. Arthur Heyman, M.D. Michael Holtzman, M.D. Herbert Mallison, M.D. Charles Carrington Polk, M.D.
Hudson	Edward Alpert, M.D. Michael Conti, M.D. Max Herman Miller, M.D.	Passaic	
		Union	

* Deceased

Reception for Recipients and Families Following Ceremony

Annual Trauma Oration

Saturday, May 15

1:00 p.m.

Prevention of Deaths After Injuries

William T. Fitts, M.D., Professor of Surgery, University of Pennsylvania; and Chief of Surgery, Division B, Hospital of the University of Pennsylvania, Philadelphia.

The New Jersey Committee on Trauma of the American College of Surgeons will present its Annual Trauma Oration on Saturday, May 15, during the Annual Meeting of The Medical Society of New Jersey. Doctor Fitts is Editor of the journal *Trauma*, and Vice-Chairman of the Trauma Committee of the American College of Surgeons. He gave the Annual Trauma Oration at the Clinical Congress of the American College of Surgeons in October 1970. Doctor Fitts is a Fellow of the American College of Surgeons, and has contributed a large number of articles to the literature in the field of trauma.

(All members of The Medical Society of New Jersey and other physicians are invited to attend).

1971 Annual Meeting

General Session

Saturday, May 15

3:15 p.m.

Presiding

Emanuel M. Satulsky, M.D., President

A Review and Report on Recent Developments and the Current Status of the College of Medicine and Dentistry of New Jersey

Representative Speakers:

College of Medicine and Dentistry of New Jersey at Newark

College of Medicine and Dentistry of New Jersey at Rutgers

Question and Answer Period

(All members, official guests and their wives, and members of the Woman's Auxiliary are cordially invited to attend.)

—1971 *Annual Meeting*—

CABARET

Saturday, May 15

9:00 p.m.

Master of Ceremonies

Louis K. Collins, M.D.

Program

Excerpts from past performances by the
Phi Delta Epsilon Players

Dr. Donald J. Holtzman
Dr. Milton L. Fischgrund
Dr. Burton B. Bergman
Dr. Ernest P. Greenberg

Dr. Irving R. Fox
Dr. and Mrs. H. J. Orris
Mrs. Barbara Furst
Mrs. Paula Yaeger

Dancing until midnight

—1971 *Annual Meeting*—

DINNER-DANCE

Monday, May 17

7:00 p.m.

Honoring

President Emanuel M. Satulsky

Toastmaster

Richard I. Nevin

Welcome

Mrs. Alexander U. Bertland, President
Woman's Auxiliary

Introductions

Mrs. Donald A. McLean, President-Elect
Woman's Auxiliary
E. Vernon Davis, M.D., President-Elect
The Medical Society of New Jersey

Presentations

Fellow's Key

To: Emanuel M. Satulsky, M.D., President

By: Nicholas A. Bertha, M.D., Immediate Past-
President

Fellowette's Pin

To: Mrs. Alexander U. Bertland,
President, Woman's Auxiliary

By: Emanuel M. Satulsky, M.D., President
The Medical Society of New Jersey

Entertainment—Scotch Plains Players

Music and Dancing

Martin King Orchestra Associates

1971 Annual Meeting

SPECIAL SESSION

DRUG ABUSE

Sunday, May 16

9:30 a.m.

Arranged in cooperation with the College of Medicine and Dentistry of New Jersey

All members, official guests, and their wives, and members of the Woman's Auxiliary are cordially invited to attend

9:30 a.m. **Medical Complications of Drug Abuse**
DONALD B. LOURIA, M.D., Professor and Chairman, Department of Public Health and Preventive Medicine, College of Medicine and Dentistry of New Jersey at Newark

10:00 a.m. **Treatment of Acute Drug Abuse Emergencies**
EDWARD A. WOLFSON, M.D., Associate Professor and Director, Division of Drug Abuse, Department of Public Health and Preventive Medicine, College of Medicine and Dentistry of New Jersey at Newark

10:30 a.m. **Long Term Rehabilitation and Treatment: Referrals and Modalities**
STANLEY EINSTEIN, Ph.D., Associate Director and Educational Coordinator, Division of Drug Abuse, College of Medicine and Dentistry of New Jersey at Newark

11:00 a.m. **Drug Use in New Jersey Schools: Responsibilities for the Physician**

Panel and Audience Discussion

Moderator:
EDWARD A. WOLFSON, M.D.

Physicians are becoming more involved in the contemporary drug scene through participation in community, hospital, and local medical society drug abuse committees in addition to their trusted role as family doctors. With increasing frequency, in emergency rooms, medical offices and via the telephone, physicians are being confronted by concerned parents and citizens as well as by drug abusers in the acute stages of drug intoxication.

The panel will present and discuss the diagnostic

challenges, the medical treatment of the acute phase (including the frequent need for non-chemical intervention), the medical and psychiatric complications (acute and chronic) of drug abuse, long term rehabilitation and treatment, referred systems, deceptions in the illicit drug market, and the drug scene in New Jersey schools (emphasizing the physician's role and responsibilities).

Ample time will be allotted for questions and audience participation.

VISIT THE EXHIBITS

A THREE-WAY TREAT

One of the colorful aspects of our convention is the interesting array of exhibits. This year, as usual, we have three classes—

Informational — Scientific — Technical

The exhibits help to defray the cost of your Annual Meeting. Take time to visit each booth. There is a wealth of new information available. Representatives will be present to answer your questions.

1971 *Annual Meeting*

REFERENCE COMMITTEES

Sunday, 11:00 a.m.

May 16, 1971

Reference Committee on Constitution and Bylaws Room 1333, Tower Floor

Reports of the:
Committee on Revision of Constitution and Bylaws
Amendments to Constitution
Amendments to Bylaws

Reference Committee "A" Viking Room, Tower Floor

Reports of the:
President
Board of Trustees
Secretary
Judicial Council
Executive Director
Committee on Credentials

Reference Committee "B" Room 1344, Tower Floor

Reports of the:
Treasurer
Committee on Finance and Budget
Committee on Publication
Committee on Medical Student Loan Fund
Committee on Project Hope/Vietnam

Reference Committee "C" Mandarin Room, Tower Floor

Reports of the:
Medical-Surgical Plan of New Jersey
Committee on Medical Defense and Insurance
Committee on Retirement Plan for Physicians

Reference Committee "D" Room 1337, Tower Floor

Reports of the:
Committee on Medical Education
Committee on Medicine and Religion
Committee on Emergency Medical Care
Committee on Traffic Safety

Reference Committee "E" West Room, Tower Floor

Reports of the:
Council on Legislation
Council on Public Relations

Reference Committee "F" Rutland Room, First Floor

Reports of the:
Council on Medical Services, and its Special Committee on Occupational Health, Workmen's Compensation and Rehabilitation
Council on Mental Health, and its Special Committees on:
Alcoholism
Drug Abuse
Emotional Disorders of Childhood and Adolescence
Mental Retardation
Seizures

Reference Committee "G" Derbyshire Room, First Floor

Reports of the:
Council on Public Health, and its Special Committees on:
Cancer Control
Child Health
Conservation of Vision, Hearing, and Speech
Environmental Health
Maternal and Infant Welfare

Reference Committee "H" Rowsley Room, First Floor

Reports of the:
Committee on Annual Meeting, and its Special Committees on:
Scientific Exhibits
Scientific Program
Committee on Honorary Membership
Advisory Committee to the Woman's Auxiliary
Nominations for Emeritus Membership

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

1971 Annual Meeting

HOUSE OF DELEGATES

Saturday, 2:30 p.m.
Sunday, 3:30 p.m.
Tuesday, 9:00 a.m.

May 15, 1971
May 16, 1971
May 18, 1971

President—Emanuel M. Satulsky, M.D., Elizabeth Secretary—Charles L. Cuniff, M.D., Jersey City
Speaker—Jesse McCall, M.D., Newton

Sessions

Saturday, May 15—2:30 p.m.

First Session

Invocation
Elbert H. Pogue, M.D., Elizabeth

Call to Order by the Speaker
Jesse McCall, M.D.

Organization of the House

Transactions of the 1970 House of Delegates

Introduction of Guests and Delegates from Other States

Annual and Supplemental Reports

Proposed Amendments to the Constitution and Bylaws

Resolutions

New Business

Announcements

Sunday, May 16—3:30 p.m.

Second Session

Report of Nominating Committee

Election

(At the conclusion of this session of the House of Delegates, the President and the President-Elect each will present his address.)

Tuesday, May 18—9:00 a.m.

Third Session

Reports of Reference Committees

Unfinished Business

Adjournment

(Luncheon Recess—1:00 to 1:30 p.m.)

OFFICES TO BE FILLED BY ELECTION—1971 ANNUAL MEETING

Office	Term	From	To	Incumbent and County
President-Elect	1 year	May 1971-May 1972		E. Vernon Davis Burlington
1st Vice-President	1 year	May 1971-May 1972		William J. D'Elia Monmouth
2nd Vice-President	1 year	May 1971-May 1972		Matthew E. Boylan Hudson
Secretary	1 year	May 1971-May 1972		Louis F. Albright Spring Lake
Treasurer	1 year	May 1971-May 1972		Samuel J. Lloyd Mercer
Trustees:				
1st District	3 years	May 1971-May 1974		*Jerome G. Kaufman Essex
2nd District	3 years	May 1971-May 1974		*Thomas C. DeCecio Bergen
5th District	3 years	May 1971-May 1974		Nicholas E. Marchione Cumberland

* Ineligible for Re-election, having served 3 full terms.

Office	Term	From	To	Incumbent and County
Judicial Councilors:	3 years	May 1971	May 1974	John L. Olpp Bergen
2nd District	3 years	May 1971	May 1974	John S. Madara Salem
AMA Delegates	2 years	Jan. 1972	Dec. 1973	Joseph P. Donnelly Hudson
	2 years	Jan. 1972	Dec. 1973	Jesse McCall Sussex
	2 years	Jan. 1972	Dec. 1973	Isaac N. Patterson Gloucester
AMA Alternate Delegates	2 years	Jan. 1972	Dec. 1973	Joseph R. Jehl Passaic
	2 years	Jan. 1972	Dec. 1973	Emanuel M. Satulsky Union
	2 years	Jan. 1972	Dec. 1973	Robert E. Verdon Bergen
Delegates and Alternate Delegates to Other States:				
New York:				
Delegate	1 year	1972 Annual Meeting		Albert F. Moriconi Mercer
Alternate	1 year	1972 Annual Meeting		Peter H. Marvel Atlantic
Connecticut:				
Delegate	1 year	1972 Annual Meeting		Joseph A. Lepree Union
Alternate	1 year	1972 Annual Meeting		Josiah C. McCracken, Jr. Atlantic
Administrative Councils:				
Legislation:				
1st District	3 years	May 1971	May 1974	Harvey P. Einhorn Essex
2nd District	2 years	May 1971	May 1973	†John J. Crosby, Jr. Hudson
3rd District	2 years	May 1971	May 1973	†Leon A. Fraser Mercer
4th District	3 years	May 1971	May 1974	Meyer L. Abrams Burlington
Medical Services:				
1st District	3 years	May 1971	May 1974	**Francis J. Benz Morris
4th District	3 years	May 1971	May 1974	Robert S. Gamon, Jr. Camden
Mental Health:				
1st District	3 years	May 1971	May 1974	Arnold M. Kallen Essex
2nd District	3 years	May 1971	May 1974	Eugene Resnick Bergen
Public Health:				
1st District	3 years	May 1971	May 1974	George I. Erdman Union
4th District	3 years	May 1971	May 1974	Frederick C. Stellar Monmouth
Public Relations:				
1st District	3 years	May 1971	May 1974	**S. William Kalb Essex
2nd District	3 years	May 1971	May 1974	Frank R. Begen Bergen
4th District	3 years	May 1971	May 1974	John P. Kengeter Ocean
Standing Committees:				
Annual Meeting	3 years	May 1971	May 1974	James A. Rogers Passaic
Finance and Budget	3 years	May 1971	May 1974	G. Thomas DeFusco Hudson
Medical Defense and Insurance	3 years	May 1971	May 1974	Jesse Schulman Ocean
Medical Education	3 years	May 1971	May 1974	Arthur Bernstein Essex
Publication	3 years	May 1971	May 1974	**James J. Fitzpatrick Mercer
Woman's Auxiliary Advisory	3 years	May 1971	May 1974	**Ralph K. Bush Camden

† Appointed by Board until 1971 Annual Meeting.

** Ineligible for re-election, having served 3 consecutive terms.

1971 Annual Meeting

SPEAKERS

Saturday through Tuesday
May 15 to 18, 1971

Chalfonte-Haddon Hall
Atlantic City

Abraham, Emanuel, M.D., Asbury Park
Alpert, Joseph, M.D., Millburn
Arbesman, Mr. Paul H., New York
Arnold, Samuel J., M.D., Morristown

Barbero, Giulio J., M.D., Philadelphia
Betcher, Albert M., M.D., New York
Blackwood, James M., M.D., Newark
Bloomenstein, Richard B., M.D., Paterson
Breen, James L., M.D., Maplewood
Brodkin, Roger H., M.D., Irvington
Byron, Herve M., M.D., Englewood

Cannilla, Joel E., M.D., East Orange
Chusid, Leslie, M.D., New York
Clark, Wallace H., Jr., M.D., Philadelphia
Cooke, Robert E., M.D., Baltimore
Cross, Richard J., M.D., New Brunswick
Cunneff, Raymond L., Jr., M.D., Red Bank

DelGuercio, Louis R. M., M.D., Bronx
deRoeth, Andrew, Jr., M.D., New York
Deutsch, Lawrence, M.D., Englewood
Donnelly, Joseph P., M.D., Jersey City
Dreifus, Leonard S., M.D., Philadelphia

Edeiken, Jack, M.D., Philadelphia
Einstein, Stanley, Ph.D., Newark

Freiberger, Robert H., M.D., New York
Fritts, William T., M.D., Philadelphia
Fullilove, Robert E., Jr., M.D., Belleville

Galin, Miles A., M.D., New York
Gartland, John J., M.D., Philadelphia
Girsh, Leonard S., M.D., Philadelphia
Goger, Pauline R., M.D., Flemington
Goldfield, Martin, M.D., Willingboro
Gordon, Myron, M.D., New York
Green, Carl, M.D., Paterson
Gregori, Caterina A., M.D., Livingston
Groff, Diller B., M.D., Newark

Kaback, Michael M., M.D., Baltimore
Kemp, Norval F., M.D., Jersey City
Ketyer, Sidney, M.D., Elizabeth
Kimler, William D., M.D., Haddon Heights

Kushnick, Theodore, M.D., Newark

Lawless, Edward T., M.D., Paterson
Levene, Ralph Z., M.D., New York
Liebow, Averill A., M.D., San Diego
Louria, Donald B., M.D., Newark
Ludin, Edward N., M.D., Cherry Hill
Lukas, Daniel S., M.D., New York

Madaras, John S., Jr., M.D., East Orange
Malton, S. Donald, M.D., Morristown
Marshak, Richard H., M.D., New York
Mayer, Bernard W., M.D., Gladwyn, Pa.
Moseley, Roger V., M.D., Princeton

Nicholson, William J., Ph.D., New York
Niguidula, Faustino N., M.D., Philadelphia

Owen, Mr. Jack, Princeton

Portfolio, A. G., M.D., Ridgewood
Puchner, Gerhard, M.D., Princeton

Rigor, Benjamin M., M.D., Newark
Rose, F. Leland, M.D., Haddonfield
Rush, Benjamin, M.D., Newark

Sall, Sanford, M.D., New York
Sanfilippo, Louis J., M.D., Livingston
Savel, Lewis E., M.D., South Orange
Seebode, Joseph J., M.D., Newark
Selikoff, Irving J., M.D., Paterson
Sherlock, Paul, M.D., New York
Shoshkes, Milton, M.D., Millburn
Solomon, Harvey M., M.D., Nutley
Spivack, Jerome, M.D., Irvington
Sweeney, William J. III, M.D., New York
Syracuse, Paul F., M.D., Irvington

Tucker, Gabriel F., Jr., M.D., Philadelphia
Tucker, John A., M.D., Philadelphia

Walker, John C. Jr., M.D., East Orange
Weinberg, Sidney R., M.D., Brooklyn
Wolfson, Edward A., M.D., Newark
Woodruff, J. Donald, M.D., Baltimore
Wuester, William O., M.D., Elizabeth

—1971 Annual Meeting—

SCIENTIFIC SECTION OFFICERS

Saturday through Tuesday
May 15 to 18, 1971

Chalfonte-Haddon Hall
Atlantic City

Allergy

CHAIRMAN—Mary B. Hall, M.D., Trenton
SECRETARY—J. Loren Rosenberg, M.D., East Orange

Anesthesiology

CHAIRMAN—Joanne R. Smith, M.D., Glen Rock
SECRETARY—Henry A. Connolly, Jr., M.D., Summit

Cardiovascular Diseases

CHAIRMAN—Leonard J. Lesniak, M.D., Wayne
SECRETARY—Joel E. Cannilla, M.D., Mountain Lakes

Chest Diseases

CHAIRMAN—William S. Kelhoffer, M.D., Roselle Park
SECRETARY—A. Marshall Smith, Jr., M.D.,
New Brunswick

Clinical Pathology

CHAIRMAN—Joseph P. Greeley, M.D., Westfield
SECRETARY—Lawrence Wilkinson, M.D., Ridgewood

Dermatology

CHAIRMAN—William Cohen, M.D., Trenton
SECRETARY—Roger H. Brodtkin, M.D., Irvington

Gastroenterology and Proctology

CHAIRMAN—Herbert Z. Greenfield, M.D., East Orange

General Practice

CHAIRMAN—Edmund E. Jacobitti, M.D., Maywood
SECRETARY—Daniel N. Burbank, M.D., Cedar Grove

Medicine

CHAIRMAN—James G. Dickensheets, M.D., Camden
SECRETARY—David A. Gehring, M.D., Woodbury

Obstetrics and Gynecology

CHAIRMAN—Caterina A. Gregori, M.D., Newark
SECRETARY—Jerome A. Dolan, M.D., Paterson

Ophthalmology

CHAIRMAN—A. G. Portfolio, M.D., Ridgewood
SECRETARY—Raymond E. Adams, M.D., Cherry Hill

Orthopedic Surgery

CHAIRMAN—L. Arne Skilbred, M.D., Montclair
SECRETARY—Bernard A. Rineberg, M.D., New Brunswick

Otolaryngology

CHAIRMAN—Myles G. Turtz, M.D., Cherry Hill
SECRETARY—S. Thomas Westerman, M.D., Red Bank

Pediatrics

CHAIRMAN—Arthur F. Fost, M.D., Belleville
SECRETARY—Wesley Boodish, M.D., Maplewood

Plastic and Reconstructive Surgery

CHAIRMAN—John J. Bowe, M.D., Paterson
SECRETARY—S. Donald Maltom, M.D., Morristown

Psychiatry and Neurology

CHAIRMAN—Eugene V. Resnick, M.D., Paramus
SECRETARY—Daniel L. Goldstein, M.D., Hackensack

Radiology

CHAIRMAN—Franklin Wald, M.D., Edison
SECRETARY—David I. Kingsley, M.D., Edison

Rheumatism

CHAIRMAN—Joseph M. Marchesano, M.D., Bloomfield
SECRETARY—Walter Schwarzschild, M.D., Cherry Hill

Surgery

CHAIRMAN—Donald K. Brief, M.D., Millburn
SECRETARY—William P. Burks, M.D., Princeton

Urology

CHAIRMAN—Samuel J. Arnold, M.D., Morristown
SECRETARY—Robert E. Fullilove, Jr., M.D., Newark

1971 Annual Meeting

MOTION PICTURE THEATER

Saturday, May 15

Sunday, May 16

Monday, May 17

2 p.m.

10 a.m. and 2 p.m.

10 a.m. and 2 p.m.

Arranged and presented through the cooperation of Roche Laboratories,
Division of Hoffmann-LaRoche, Inc., Nutley.

Management of Parkinson's Disease and Syndrome with Levodopa

Melvin D. Yahr, M.D., Professor, Department of Neurology, and Roger C. Duvoisin, M.D., Associate Professor of Neurology, Columbia University College of Physicians and Surgeons, New York.

After tracing the path of pharmacologic research which led to the finding that levodopa is effective in altering the symptoms of Parkinson's disease, the film focuses on the clinical use of the drug at this time. Included is discussion of indications and contraindications for levodopa therapy, recommended treatment schedules and some important therapeutic considerations, and demonstration of the results of therapy in some patients.

Suicide Prevention—The Physician's Role

Karl Menninger, M.D., The Menninger Foundation, Topeka, Kansas

In five authentic case histories—including that of a practicing physician — this film demonstrates ways in which the physician can recognize suicidal tendencies in the patient. The film begins with a woman's suicidal death, and asks, "Was there anything the physician might have done to avert this tragedy?" A summary of the growing problem of suicide, as it relates to the practicing physician, is made by Dr. Menninger.

Corps Profond

Produced in France by Igor Barriere and Etienne Lalou, prominent medical programmers for French television; script written for English-speaking medical audiences by Martin E. Gordon, M.D., Associate Clinical Professor of Medicine, Yale School of Medicine, New Haven.

The film presents a provocative visualization within

many organ systems rarely seen before. The use of new endoscopic, radiographic, and microscopic methods allow visual presentation of some of the unique workings of the human body, which are awesome even to the most knowledgeable of physicians.

Hiatal Hernia/Esophagitis

David Katz, M.D., Associate Professor of Medicine, Section of Gastroenterology, New York Medical College, New York.

This film discusses the causes, diagnosis, and treatment of hiatal hernia and its often-related condition, erosive esophagitis. Possible complications resulting from untreated hernia are reviewed and illustrated.

Diagnostic modalities such as esophagoscopy, cine x-ray, intraluminal manometry, and the modified Bernstein test are demonstrated and discussed as they relate to the presence, types, and extent of hiatal hernias and their complications.

The medical and surgical treatments of hiatal hernia, esophagitis, and related symptoms are also presented.

Clinical Nuclear Medicine

Millard N. Croll, M.D., Associate Professor of Radiology, Hahnemann Medical College and Hospital, Philadelphia.

This is a completely new and updated film describing many recent advances in the uses of radioactive drugs for clinical diagnosis and treatment, specifically detailing the techniques and methodology of radioisotope scanning and autofluoroscopy and the attendant laboratory procedures.

VISIT THE EXHIBITS

Scientific — Informational — Technical

NOTE CHANGE IN TIME: From noon on Saturday and all day Sunday and Monday

1971 Annual Meeting

SCIENTIFIC PROGRAM

Sunday, May 16
Monday, May 17

Scientific Section
Sessions

Scientific Section Sessions

Sunday Morning, May 16

Chest Diseases

(Co-sponsored by New Jersey Chapter, American College of Chest Physicians)

9:30 a.m. Medical and Surgical Aspects of Pulmonary Embolism

JOEL E. CANNILLA, M.D., Staff Physician, Veterans Administration Hospital East Orange; and Clinical Assistant Professor of Medicine, College of Medicine and Dentistry of New Jersey at Newark

The clinical picture of pulmonary embolus is highly variable. With massive pulmonary emboli, the presenting symptoms can be shock, systemic hypotension or sudden death. Small pulmonary emboli may produce only unexplained fever, tachypnea, tachycardia, or dyspnea. Physical findings are also as non-specific. Chest x-ray, electrocardiogram, and enzyme studies are valuable when positive but do not rule out the diagnosis when negative. The most useful tests for the definitive diagnosis are lung scans and pulmonary angiography. Treatment is aimed primarily at the prevention of further thromboembolic episodes.

JOHN S. MADARAS, JR., M.D., Assistant Attending Thoracic Surgeon, Clara Maass Memorial Hospital, Belleville

Pulmonary embolism is a serious complication of many medical and surgical disorders. Although anticoagulants are effective for venous thromboembolism in most patients, failure of this method with further pulmonary embolization continues to occur. Indications and methods of interruption of the inferior vena cava are here presented. Pulmonary embolotomy for acute massive pulmonary embolism (using temporary cardiopulmonary bypass) will be discussed with the presentation of several cases. New methods, including thrombolytic enzymes, will be summarized.

SIDNEY KETTER, M.D., Chief Radiologist, St. Elizabeth Hospital, Elizabeth; and Clinical Associate Professor of Radiology, College of Medicine and Dentistry of New Jersey at Newark

Radioactive isotopes in diagnosing pulmonary embolization will be discussed. The rationale, method, and examples will be presented, and various pitfalls in diagnosis will be reviewed.

10:30 a.m. Hypoxemia—Management by Selection of Appropriate Oxygen Devices Using Arterial Gas Guidelines

E. L. Chusid, M.D., Chief, Pulmonary Laboratory, Assistant Clinical Professor of Medicine, Mt. Sinai School of Medicine, New York

Hypoxemia is arterial oxygen tension below 80 mm. Hg. Oxygen tensions below this level may be categorized into levels of severity and this enables the physician to gauge responses to oxygen administration. Detection of shunts, changes in pH and PaCO₂, and rises in PaO₂ guide the selection of oxygen devices. Those available include graded-low concentration technics, ventilators (with and without continuous positive pressure—CPPV), membrane oxygenation, and hyperbaric chambers. The result should be acceptable PaCO₂-60 mm. Hg. and the prevention of oxygen toxicity.

Question and Answer Period

11:30 a.m. Business Meeting—Election of Officers

11:45 a.m. Vislt to Exhibits

12 noon Luncheon-Meeting — New Jersey Chapter, American College of Chest Physicians

Reservations: R. E. MILLER, M.D.
1313 West State Street
Trenton 08618

Obstetrics and Gynecology

9:30 a.m. Symposium on Contraception: Past, Present, Future

Moderator:

CATERINA A. GREGORI, M.D., Chairman, Section on Obstetrics and Gynecology

JAMES L. BREEN, M.D., Director, Department of Obstetrics and Gynecology, Saint Barnabas Medical Center, Livingston; and Clinical Associate Professor, Department of Gynecology and Obstetrics, College of Medicine and Dentistry of New Jersey at Newark

A brief outline is here offered, reviewing the moral, ethical, and professional aspects of contraception from man's beginning interest in the prevention of pregnancy. The various technics and modalities utilized by both men and women through the centuries will be presented, as will the background of many of the concepts presently utilized in the prevention of intrauterine pregnancies.

LEWIS E. SAVEL, M.D., Attending, Department of Obstetrics and Gynecology, Newark Beth Israel Medical Center; and Clinical Associate Professor, Department of Gynecology and Obstetrics, College of Medicine and Dentistry of New Jersey at Newark

The contraceptive methods currently available and commonly being prescribed are reviewed. The advantages of each technic presented, including the statistical results to be expected. The contraindications and disadvantages of the various methods are discussed. Over-all presentation is practical. The problems and decisions facing the practitioner are evaluated from the point of view of the patient and the clinical gynecologist.

MYRON GORDON, M.D., Director, Family Planning Service; and Associate Professor, Department of Obstetrics and Gynecology, New York Medical College-Metropolitan Hospital Center, New York

The future development of contraceptive modalities is not only dependent upon the state of the art at present, but will be strongly influenced by other interrelated factors. Among these are (1) the development of meaningful national and international commitments to the dual goals of the elimination of unwanted fertility and the limitation of population growth; (2) the mobilization of the necessary political-social-economic forces to ensure public recognition and acceptance of these goals; (3) recognition of the need for a partnership between government and the private industrial sector in the development of future significant contraceptive agents; and (4) variations in target populations (i.e. developed and underdeveloped countries, unmarried and married) make it probable that several methods of contraception will be needed. Each method will not necessarily have equal applicability, safety, or effectiveness.

Several examples of present future research will be presented to illustrate the state of the art, and the factors above listed.

11:30 a.m. Business Meeting—Election of Officers

11:45 a.m. Visit to Exhibits

12 noon Luncheon — Council of New Jersey Obstetrical and Gynecological Society
(By invitation only)

1:30 p.m. Symposium

Moderator:
F. LELAND ROSE, M.D., President New Jersey Obstetrical and Gynecological Society

What are the Gonadal Enlargements In the Female?

J. DONALD WOODRUFF, M.D., Professor, Department of Gynecology and Obstetrics, Johns Hopkins University School of Medicine, Baltimore

Summary not received

What is the Conservative Management of Ovarian Enlargement?

WILLIAM J. SWEENEY, III, M.D., Associate Professor, Department of Obstetrics and Gynecology, Cornell University Medical College, New York

Summary not received

What is the Surgical and Chemo-Therapeutic Approach to Carcinoma of the Ovary?

SANFORD SALL, M.D., Director, Gynecological Malignancy Service, New York Medical College; and Associate Professor, Department of Obstetrics and Gynecology, Metropolitan Hospital Center, New York

Cancer of the ovary accounts for more than 10,000 deaths each year and, as such, presents a constant challenge. Results are no better today than in past decades. The generally accepted treatment for ovarian carcinoma is surgery, usually total abdominal hysterectomy with bilateral salpingo-oophorectomy. In cases not amenable to complete eradication, removal of the bulk of the tumor may be beneficial. Removal of the primary site may prolong life, reduce ascites formation, and lower the incidence of intestinal complications. Greater benefit from further postoperative therapy (either radiation or chemotherapy) will be achieved with lessened bulk tumor.

What is the Radio-Therapeutic Approach to Carcinoma of the Ovary?

LOUIS J. SANFILIPPO, M.D., Director, Department of Radiotherapy, Saint Barnabas Medical Center, Livingston; and Associate Professor, Department of Radiotherapy, Albert Einstein College of Medicine of Yeshiva University, New York

Radiation therapy is an important adjunct in the palliative or curative treatment of ovarian carcinoma and should be carefully integrated with surgery and/or chemotherapy. Megavoltage irradiation technics have broadened the scope of radiotherapy because of improved tolerance and increased effectiveness.

Postoperative irradiation may enhance cure rates in Stages I and IIa, and produce cures after subtotal resection of Stage IIb and III cases. Combined treatment affords palliation to many with far-advanced disease. A small experience with preoperative irradiation for advanced stages suggests its role should be expanded.

3:45 p.m. Visit to Exhibits

4:00 p.m. Annual Meeting—New Jersey Obstetrical and Gynecological Society

8:00 p.m. **Dinner** — New Jersey Obstetrical and Gynecological Society
Reservations: JOSEPH A. RIGGS, M.D.
1533 Haddon Avenue
Camden 08103
(All members are cordially invited)

Otolaryngology

9:30 a.m. **Peroral Endoscopy in Infants and Children**
GABRIEL F. TUCKER, JR., M.D., Clinical Professor, Department of Laryngology and Bronchoesophagology, The Chevalier Jackson Clinic, Temple University Health Sciences Center, Philadelphia

Summary not received

JOHN A. TUCKER, M.D., Associate Professor, Department of Bronchoesophagology and Laryngeal Surgery, Hospital of the University of Pennsylvania, Philadelphia

Summary not received

FAUSTINO N. NIGUIDULA, M.D., Associate Professor of Surgery, Temple University; and Director of Thoracic and Cardiovascular Surgery, St. Christopher's Hospital for Children, Philadelphia

Summary not received

BERNARD W. MAYER, M.D., Associate Professor in Pediatrics (Anesthesiology), St. Christopher's Hospital for Children, Philadelphia

Summary not received

Panel Discussion

11:30 a.m. **Business Meeting—Election of Officers**

11:45 a.m. **Visit to Exhibits**

Visit The Exhibits

Informational
Scientific
Technical

May 15-17

Haddon Hall

Sunday Afternoon, May 16

Anesthesiology

12:30 p.m. **Luncheon**—New Jersey State Society of Anesthesiologists
Reservations: JOANNE R. SMITH, M.D.
180 East 21st Street
Paterson 07513

1:30 p.m. **Development, Design and Deficiencies of Anesthesia Vaporizers**
ALBERT M. BETCHER, M.D., Director Department of Anesthesiology, Hospital for Joint Diseases and Medical Center and Professor of Anesthesiology, Mt. Sinai School of Medicine, City University of New York, New York

The earliest attempts to produce surgical pain relief were by inhaling fumes of burning hemp, a soporific sponge, or alcohol vapor. Morton was the first to use a vaporizer for anesthesia. This was in 1846. Succeeding devices produced asphyxia or ignored the physical principles of vaporization except for that of John Snow. For over a hundred years various "improvements" in vaporizers remained ineffectual and relatively unsafe until Morris retraced the steps of the others and developed the copper kettle in 1952. Other precision vaporizers have been developed since. How much reliance we can place on these delicate mechanical devices to deliver accurate concentrations is still questionable.

2:30 p.m. **Question and Answer Period**
Discussor, BENJAMIN M. RIGOR, M.D., Acting Chief, Department of Anesthesiology, College of Medicine and Dentistry of New Jersey at Newark

3:00 p.m. **Business Meeting—Election of Officers**

3:15 p.m. **Visit to Exhibits**

Cardiovascular Diseases

11:30 a.m. **Dutch Treat Luncheon**—American College of Cardiology
Reservations: L. J. LESNIAK, M.D.
330 Ratzer Road
Wayne 07470

1:00 p.m. **Symposium on Digitalis Pharmacokinetics of Digitoxin**
DANIEL S. LUKAS, M.D., Chief of Cardiopulmonary Service, Department of Medicine, Memorial Hospital; and Associate Professor of Medicine, Cornell University of Medical College, New York

Summary not received

Drug Interactions Involving Cardiovascular Drugs with Special Reference to Digitalis

HARVEY M. SOLOMON, M.D., Associate Director, Department of Clinical Pharmacology, Hoffmann-LaRoche, Inc., Nutley; and Clinical Assistant Professor of Medicine, College of Medicine and Dentistry of New Jersey at Newark

Summary not received

Current Concepts of the Electrophysiologic Actions of Digitalis

LEONARD S. DREIFUS, M.D., Research Associate Professor of Physiology and Biophysics, Hahnemann Medical Center, Philadelphia

Digitalis possesses important but divergent actions both in low concentrations and in the presence of alteration of serum potassium. Administration of digitalis in the lower dose range enhances conduction, increases membrane resting potential, and alters action potential duration very little. In larger concentrations, conduction velocity is decreased and the action potential duration is markedly shortened. In addition, enhancement of phase 4 diastolic depolarization may lead to ectopic pulse formation and tachycardia, particularly in the His-Purkinje system. The effect of digitalis on A-V transmission is predominantly to slow conduction in the internodal regions of the A-V transmission system. It has little effect on intra-atrial or subjunctional conduction except in extremely high dosage levels. The electrophysiologic actions of digitalis reduce the ventricular rate in the presence of supraventricular tachycardias by delaying A-V conduction but may predispose to atopic impulse formation due to enhanced automatic activity.

2:30 p.m. Panel Discussion

Moderator:

WILLIAM B. ABRAMS, M.D., Director, Department of Clinical Pharmacology, Hoffmann-La Roche, Inc., Nutley; and Clinical Associate Professor of Medicine, College of Medicine and Dentistry of New Jersey at Newark

3:00 p.m. Business Meeting—Election of Officers

3:15 p.m. Visit to Exhibits

Psychiatry and Neurology

(Cosponsored by New Jersey Neuropsychiatric Association and New Jersey Psychoanalytic Society)

1:00 p.m. The "Difficult" Patient in Medical Practice

LAWRENCE DEUTSCH, M.D., Englewood; Clinical Associate Professor of Psychiatry, State University of New York, Downstate Medical Center, New York; and Consultant Psychiatrist, Hackensack Hospital, Hackensack.

Here will be developed a frame of reference for understanding and dealing with doctor-patient relationships, in terms of the dynamic nature of the transference. Specific problems presented to demonstrate the applicability of these principles in seemingly diverse situations include: understanding basic unconscious hostility to physicians, the management of seductive patients, reassuring anxious patients, handling patients' ambivalence at being referred for consultations, and difficulties in joint management of psychosomatic patients.

Discussors: PAUL F. SYRACUSE, M.D., Irvington; Assistant Attending in Psychiatry, Clara Maass Memorial Hospital, Belleville; and Clinical Instructor in Psychiatry, Veterans Administration Hospital, East Orange

MILTON SHOSHKES, M.D., Millburn; Associate Attending in Internal Medicine, Overlook Hospital, Summit

3:00 p.m. Business Meeting—Election of Officers

3:15 p.m. Visit to Exhibits

Monday Morning, May 17

Allergy Medicine

9:30 a.m. Symposium on Air Pollution and Environmental Health

Epidemiology of Asthma in Children in Philadelphia

LEONARD S. GIRSH, M.D., Assistant Professor of Medicine-Allergy, Temple University Medical Center; and Director, Department of Allergy, St. Christopher's Hospital for Children, Philadelphia

Among a group of asthmatic children, a continuing study was made of the possible correlations between weather patterns, air pollution, and bronchial asthma. The survey was done at St. Christopher's Hospital for Children. We found a three-fold greater incidence of bronchial asthma during days of noteworthy high air pollution. On days of high air pollution, stagnant air led to a nine-fold increase in the incidence of asthma compared with the rate when the air was cleaner and less stagnant. Of the 280 days which had neither high barometric pressure nor increased air pollution, there were only 8 days (3 per cent) with an increased frequency of asthma. Stable weather with stagnant air seems to correlate with peak incidences of bronchial asthma. Evidence suggests that the increased air pollution associated with these weather conditions is a causative factor. It is suggested that an asthma index may be derived from meteorologic and air pollution data to help predict such peak incidences.

Control of Asbestosis
IRVING J. SELIKOFF, M.D., Paterson;
Professor of Medicine and Community
Medicine, Mt. Sinai School of Medi-
cine, New York, and

WILLIAM J. NICHOLSON, Ph.D., As-
sistant Professor of Community Medi-
cine, Mt. Sinai School of Medicine,
New York

Summary not received

Federal Role in Air Pollution Control
MR. PAUL H. ARBESMAN, Program
Advisor, Air Pollution Control-Environ-
mental Protection Agency, New York

A description of the Region II area and the Re-
gional Air Pollution Control Office's functions will
be given. The Clean Air Act of 1970 will be dis-
cussed in relation to new areas of federal re-
sponsibility and the new deadline dates for State
action under this law. Finally, New Jersey's air
pollution control program will be reviewed from
a federal grant standpoint.

11:00 a.m. Question and Answer Period

11:30 a.m. Business Meeting—Election of Officers

11:45 a.m. Visit to Exhibits

12 noon Luncheon—New Jersey Allergy Society
Reservations: M. S. MATTIKOW, M.D.
330 Ratzer Road
Wayne 07470

**12 noon Luncheon—New Jersey Society of In-
ternal Medicine**
Reservations: NORVAL F. KEMP, M.D.
106 Sherman Place
Jersey City 07307

**1:30 p.m. Symposium on Medical Socio-Eco-
nomics**

Moderator:
NORVAL F. KEMP, M.D., President,
New Jersey Society of Internal Medicine

The Medical Associate
RICHARD J. CROSS, M.D., Professor of
Medicine and Acting Director, Depart-
ment of Community Medicine, College
of Medicine and Dentistry of New
Jersey-Rutgers Medical School

Rutgers Medical School and Livingston College
are collaborating on a four-year educational pro-
gram designed to develop a new type of medical
auxiliary personnel. Called physicians' associates
they will function under the jurisdiction of a
licensed physician whom they will assist as directed.
They will relieve him of many of his routine tasks.
Experience indicates that such assistants can
greatly increase a physician's productivity and
appreciably alleviate the shortage of doctors.

**Peer Review—As Seen by the Insur-
ance Carrier**
JOSEPH P. DONNELLY, M.D., Presi-
dent, Medical-Surgical Plan of New
Jersey

Summary not received

Peer Review—As Seen by the Hospital
MR. JACK OWEN, President, New
Jersey Hospital Association

Peer review from the hospital's point of view
should accomplish two major objectives. First, it
should be designed and operated by physicians in
a fashion which will assure the trustees who are
responsible for the operation of the hospital that
good medical practice is being followed. Secondly,
it should provide a mechanism whereby the prac-
ticing physician can evaluate his performance based
on statistics and judgments of his peers. It pro-
vides him with measurements so as to avoid prac-
ticing defensive medicine. A good peer review pro-
gram must provide more than a mechanism for
punishment.

Peer Review—As Seen by the Internist
EMANUEL ABRAHAM, M.D., Director,
Department of Medicine, Jersey Shore
Medical Center; and President-Elect,
New Jersey Society of Internal Medi-
cine

Peer Review for the internist means review of
under as well as over utilization; study of patient
and physician profiles; dedication to improve the
quality of physicians and generated services. It
should not be limited to review of claims, costs,
or cursory utilization review as is now practiced
in our hospitals.

**3:00 p.m. Annual Meeting—New Jersey Society
of Internal Medicine**

Clinical Pathology Dermatology

(Cosponsored by New Jersey Dermatological
Society and New Jersey Society of Pathologists)

**9:30 a.m. Clinical Aspects of Melanotic Lesions
of the Skin**
ROGER H. BRODKIN, M.D., Clinical
Associate Professor of Medicine and
Acting Director, Department of Derma-
tology, College of Medicine and Den-
tistry of New Jersey at Newark

Does malignancy melanoma arise from a benign
junction nevus? Or, is the lesion a melanoma from
the start? We do not really know the answer to
this question. This presentation explores this ques-
tion by reviewing the evolution of the common
nevus and by considering our current knowledge
to bring this question into more even balance.

10:00 a.m. Histogenesis of Melanomas in Relation to its Biologic Behavior
WALLACE H. CLARK, JR., M.D., Professor of Pathology, Temple University Medical School, Philadelphia

Summary not received

10:30 a.m. The Surgical Approach to Melanotic Lesions of the Skin
WILLIAM O. WUESTER, M.D., Attending Surgeon, Malignant and Allied Diseases, Elizabeth General Hospital; and Director, Wuester Clinic, Elizabeth

Various factors influencing treatment will be discussed; notably the type and location, previous surgery, presence of node involvement. The type of surgery will cover biopsy, definitive surgery, elective node dissection both in continuity and in discontinuity. Elective amputation indications are summarized.

11:00 a.m. Question and Answer Period

11:30 a.m. Business Meeting—Election of Officers

11:45 a.m. Visit to Exhibits

Gastroenterology and Proctology

(Cosponsored by New Jersey Proctologic Society)

9:30 a.m. Australia Antigen and Hepatitis
MARTIN GOLDFIELD, M.D., Willingboro; Director, Division of Laboratories, New Jersey State Department of Health, Trenton; and Visiting Professor in Epidemiology, College of Medicine and Dentistry of New Jersey at Newark

Summary not received

10:00 a.m. Recent Advances and Limitations of Current Technics in the Diagnosis of Gastrointestinal Cancer
PAUL SHERLOCK, M.D., Chief, Gastroenterology Service, Memorial Hospital for Cancer and Allied Diseases; and Associate Professor of Medicine, Cornell University Medical College, New York

Since more extensive surgery would not seem to be the answer for the cure of gastrointestinal cancer, earlier diagnosis with available and newer technics resulting in earlier treatment of patients when lesions are localized may be the partial answer.

Exfoliative cytology, endoscopy, radiological methods, and radioactive scanning have a definite place in diagnosis but there are limitations to these procedures. Successful screening of more patients for early diagnosis awaits the development of simpler diagnostic modalities such as biochemical or immunologic ones and the accurate selection of the population at risk, to include in a broad multiphasic screening program.

10:30 a.m. Roentgen Features of Gastrointestinal Vascular Lesions
RICHARD H. MARSHAK, M.D., Attending Radiologist, Mt. Sinai Hospital; and Clinical Professor of Roentgenology, Mt. Sinai School of Medicine, New York

Summary not received

11:00 a.m. Question and Answer Period

11:30 a.m. Business Meeting—Election of Officers

11:45 a.m. Visit to Exhibits

General Practice Pediatrics

(Cosponsored by New Jersey Academy of General Practice and New Jersey Chapter, American Academy of Pediatrics—AAGP will give 2 credits for attendance.)

9:15 a.m. Business Meeting—Election of Officers

9:30 a.m. Preventable Causes of Mental Retardation
ROBERT E. COOKE, M.D., Given Foundation Professor of Pediatrics, Johns Hopkins University School of Medicine; and Pediatrician-in-Chief, Johns Hopkins Hospital, Baltimore

Prevention of mental retardation begins with the preconception period. Prematurity and prenatal growth retardation are accompanied by an increased frequency of mental retardation. Both may be influenced by maternal factors before and during pregnancy. Prenatal disorders may be reduced by proper immunizations, appropriate diet, and careful medical management of pregnancy complications. In the neonatal period, prevention of hypoglycemia, hyperbilirubinemia, and hyperaminoacidemia may prevent mental retardation. The detailed biochemical and cytogenetic analysis of retarded infants and children can lead to proper genetic counseling and prevention of subsequent births or seriously defective infants.

Clues for the Detection of Genetic and Chromosomal Abnormality in Early Infancy

THEODORE KUSHNICK, M.D., Professor of Pediatrics, College of Medicine and Dentistry of New Jersey at Newark; and Attending Pediatrician, Martland Hospital, Newark

This discussion will center upon those aspects of the history and physical examination of infants which will enable the practicing physician to suspect more serious underlying malformations. These features include the ones associated with genetic, chromosomal or early gestational environmental etiologies. The incidences of these etiologies will be outlined in order to provide a perspective for the physician's subsequent investigations.

10:30 a.m. Intrauterine Diagnosis of Genetic Disorders
MICHAEL M. KABACK, M.D., Assistant Professor, Department of Pediatrics, Johns Hopkins University School of Medicine, Baltimore

Summary not received

11:00 a.m. Cystic Fibrosis
GIULIO J. BARBERO, M.D., Professor and Chairman, Department of Pediatrics, Hahnemann Medical College, Philadelphia

Cystic fibrosis is one of the most serious pulmonary diseases in children. This genetic disease shows signs of chronic or intermittent chest involvement (cough, dyspnea) and gastro-intestinal signs (bulky, some frequent, foul stools). It is diagnosed by the sweat test which shows an elevated sweat sodium chloride level in cystic fibrosis. Vigorous antibiotic and pulmonary treatment have improved the pattern of disease. Its pulmonary pathogenesis is unknown, but many new findings have been reported in the past few years.

11:30 a.m. Discussion

11:45 a.m. Visit to Exhibits

12 noon Luncheon-Meeting—New Jersey Chapter, American Academy of Pediatrics
Speaker: ROBERT E. COOKE, M.D.
"Acceptability vs Efficiency vs Economy in Delivery of Health Care"

Reservations: ARTHUR F. FOST, M.D.
50 Newark Avenue
Belleville 07109

Orthopedic Surgery

(Cosponsored by the New Jersey Orthopaedic Society)

9:00 a.m. Registration

9:30 a.m. Case Reports: Vertebral Fractures
CARL GREEN, M.D., St. Joseph Hospital, Paterson

Summary not received

10:00 a.m. Panel: Tibial Tubercle Transfer
RAYMOND L. CUNNEFF, JR., M.D., Attending, Department of Orthopedic Surgery, Riverview Hospital, Red Bank

Summary not received

10:30 a.m. Coffee Break

11:00 a.m. Judgment in Lumbar Disc Surgery
JOHN J. GARTLAND, M.D., Professor, Department of Orthopedic Surgery, Thomas Jefferson University School of Medicine, Philadelphia

Summary not received

11:30 a.m. Business Meeting—Election of Officers

11:45 a.m. Visit to Exhibits

12 noon Luncheon — New Jersey Orthopaedic Society

Reservations: R. L. Cunneff, M.D.
21 East Front Street
Red Bank 07701

Visit the Exhibits

Radiology Rheumatism

9:30 a.m. Bone Densitometry—Clinical Implications in Osteoporosis
JACK EDEIKEN, M.D., Chief, Radiology Division, Thomas Jefferson University School of Medicine, Philadelphia

Summary not received

10:00 a.m. Arthrography
ROBERT H. FREIBERGER, M.D., Director, Department of Radiology, Hospital for Special Surgery; and Associate Professor of Radiology, Cornell University Medical College, New York

Arthrography is a roentgen procedure allowing the demonstration and evaluation of the intra-articular spaces of joints. This procedure is finding wider acceptance and should become a standard widely available radiographic procedure. Its increasing use in recent years is caused by improvement of both radiographic equipment and the water soluble radiopaque contrast media. There is also increasingly greater demand to have graphic demonstration of a diagnosis previously made entirely by physical examination. Arthrography at the knee is detecting tears of the menisci and of the anterior cruciate ligament. These will be here illustrated. In the shoulder, arthrography is useful in the diagnosis of partial (or complete) rotator cuff tear and the confirmation of the diagnosis of frozen shoulder. In the hip, arthrography has been used for years to depict the shape of the acetabulum and femoral head primarily in cases of congenital hip dislocation. However, it has other uses as will be shown. The arthrogram has a high degree of diagnostic accuracy and when performed with proper antiseptic and aseptic technics has practically no complications.

10:30 a.m. **Immunosuppressive Drugs In the Treatment of Rheumatic Diseases**
WILLIAM D. KIMLER, M.D., Chief, Department of Rheumatology, The Cooper Hospital, Camden

Summary not received

11:00 a.m. **Question and Answer Period**

11:30 a.m. **Business Meeting—Election of Officers**

11:45 a.m. **Visit to Exhibits**

Surgery

(Cosponsored by New Jersey Chapter, American College of Surgeons)

9:30 a.m. **Symposium on Care of the Critically Ill Surgical Patient**

Cardiac Problems and Oxygen Transport in the Shock Patient
LOUIS R. M. DELGUERCIO, M.D., Director, Department of Surgery, Saint Barnabas Medical Center, Livingston; and Professor, Department of Surgery, College of Medicine and Dentistry of New Jersey at Newark

The modern treatment of shock (regardless of etiology) is dependent upon accurate physiologic assessment at the bedside. The fundamental problem is oxygen transport and utilization. For proper choice and evaluation of therapy, cardiac output and oxygen utilization must be evaluated. This paper shows how this can be accomplished at the community hospital level using simplified techniques developed in university shock research units. New concepts of treatment related to the oxygen unloading characteristics of stored bank blood will be discussed.

Respiratory Insufficiency after Injury
ROGER V. MOSELEY, M.D., Associate in Surgery, Princeton Hospital

Summary not received

Resuscitation in the Emergency Room
JAMES M. BLACKWOOD, M.D., Assistant Professor, Department of Surgery, College of Medicine and Dentistry of New Jersey at Newark

Rapid diagnosis of the kinds of patients needing resuscitation in an emergency room is essential. Methods of quickly establishing an airway and cannulating large veins are reviewed. Controversial aspects of fluid therapy in hemorrhage shock are mentioned. The "chest thump" as an initial therapeutic maneuver in cardiac arrest is emphasized. The Emergency Room physician should be willing

and able to open the chest if closed-chest cardiac massage is ineffective. A preventive maintenance system for resuscitation equipment is mandatory. Frayed or tangled defibrillator leads, burned out laryngoscope bulbs, or mal-fitting endotracheal tube connectors can result in losing precious seconds.

The Role of the Shock Team In the Care of the Critically Ill

JOSEPH ALPERT, M.D., Associate In Surgery, Newark Beth Israel Medical Center; and Associate Clinical Professor of Surgery, College of Medicine and Dentistry of New Jersey at Newark

Hemodynamic monitoring of critically ill patients should provide information (not otherwise available) that is relevant to the patient's immediate condition and indicates the therapeutic approach in his management. Furthermore, it should assist in delineating the effect of therapy.

Bed-side data acquisition and information feedback must be continuous for the development of an on-line trend analysis, since this analysis is basic to accomplishing these objectives.

Primary and derived hemodynamic data obtained from the monitoring of fifty critically ill patients will be presented to support the contention that the core clinical value of a monitoring unit still depends on a patient—physician interface and requires frequent examination and evaluation of the patient.

Neonatal Resuscitation

DILLER B. GROFF, M.D., Assistant Professor of Surgery and Director, Division of Pediatric Surgery, College of Medicine and Dentistry of New Jersey at Newark

Summary not received

Panel Discussion

Moderator:

BENJAMIN F. RUSH, M.D., Johnson & Johnson, Professor, Department of Surgery, College of Medicine and Dentistry of New Jersey at Newark

11:30 a.m. **Business Meeting—Election of Officers**

11:45 a.m. **Visit to Exhibits**

MESSAGE CENTER

courtesy of

New Jersey State Medical
Assistants Association

COFFEE LOUNGE

sponsored by

The Prudential Insurance
Company of America

Urology

(Cosponsored by New Jersey Diabetes Association)

9:30 a.m. Introduction:

ROBERT E. FULLILOVE, JR., M.D., Secretary, Section on Urology; and Attending in Urology, Clara Maass Memorial Hospital, Belleville

The Role of the Urologist in the Diagnosis and Treatment of Diabetes Mellitus

SIDNEY R. WEINBERG, M.D., Chief, Department of Urology, Jewish Hospital and Medical Center of Brooklyn; and Clinical Professor, Department of Urology, State University of New York, Downstate Medical Center

The role of the urologist in the diagnosis and treatment of diabetes mellitus is primarily to preserve renal function. The diabetic patient is prone to Kimmelstein-Wilson degeneration of the kidneys. Diabetic neuropathy may result in neurogenic dysfunction of the bladder. These incipient conditions are frequently overlooked and result in deterioration of renal function. This will be discussed. In the male, impotence is a common complication of diabetic neuropathy. Its treatment will be discussed.

10:00 a.m. Discussion

10:30 a.m. The Urine Analysis—Its Limitations The Urine Culture—Its Meaning and Limitations

Moderator:

SAMUEL J. ARNOLD, M.D., Chairman, Section on Urology; and Senior Attending, Department of Urology, Morristown Memorial Hospital

Discussors:

SIDNEY R. WEINBERG, M.D. Brooklyn
JOSEPH J. SEEBODE, M.D., Professor of Urology, College of Medicine and Dentistry of New Jersey at Newark; and Director, Department of Urology, Martland Hospital, Newark

Summary not received

PAULINE R. GOGER, M.D., Assistant Director, Department of Internal Medicine, Hunterdon Medical Center, Flemington; and Assistant Clinical Professor of Medicine, New York University School of Medicine

Summary not received

11:30 a.m. Business Meeting—Election of Officers

11:45 a.m. Visit to Exhibits

Monday Afternoon, May 17

Ophthalmology

(Cosponsored by New Jersey Academy of Ophthalmology and Otolaryngology)

2:00 p.m. Symposium on Glaucoma

MILES A. GALIN, M.D., Professor and Chairman, Department of Ophthalmology, New York Medical College, Flower and Fifth Avenue Hospitals, New York

Summary not received

RALPH Z. LEVENE, M.D., Associate Professor, Department of Ophthalmology, New York University Medical Center, New York

Summary not received

ANDREW deROETHH, JR., M.D., Assistant Professor, Department of Ophthalmology, Columbia-Presbyterian Medical Center, New York

Summary not received

Panel Discussion

Moderators:

A.G. PORTFOLIO, M.D., Attending in Ophthalmology, The Valley Hospital, Ridgewood; and Associate Clinical Professor, Department of Ophthalmology, New York University School of Medicine, New York

HERVE M. BYRON, M.D., Assistant Attending in Ophthalmology, The Englewood Hospital; and Assistant Clinical Professor, Department of Ophthalmology, College of Medicine and Dentistry of New Jersey at Newark

4:15 p.m. Business Meeting—Election of Officers

4:30 p.m. Visit to Exhibits

Plastic and Reconstructive Surgery

2:00 p.m. Symposium on Plastic Surgery in Children

Anesthetic Considerations for Pediatric Plastic Surgery

EDWARD T. LAWLESS, M.D., Director, Department of Anesthesiology, St. Joseph's Hospital, Paterson

Plastic surgery in infants and children can be associated with rather unique anesthetic problems and situations not always seen in "routine" general pediatric surgery. Several of these, such as airway safety, drug reactions and interactions and fluid maintenance are considered. The anesthesiologist and plastic surgeon, by spending a few

moments of advanced observation of the child, by advanced planning of step by step management, by proper monitoring, by reciprocal communication, and by continued post-anesthetic observation, can avert most complications that may range from mild to catastrophic.

Cleft Lip and Cleft Palate

EDWARD N. LUDIN, M.D., Cherry Hill; Chief, Department of Plastic and Reconstructive Surgery, The Cooper Hospital, Camden

The incidence of a new born with a congenital cleft lip and/or palate varies considerably. The range is from 1 per 500 to 1 per 1250. Care of the child with cleft lip and/or cleft palate is a multi-disciplined approach. Many physicians and ancillary medical personnel help take care of these youngsters. The plastic surgeon is primarily involved in repair of the deformities. He often acts as a coordinator as well. These disorders may be together or separate and from very minor uni-lateral incomplete clefts to complete bi-lateral clefts. Surgical care of these deformities varies considerably depending upon the type and extent of the cleft. Not only is the original repair of importance but the care and treatment of long term remaining deformities and those which occur as the result of further growth. Problems of speech for the cleft palate child must be followed for a long interval. Thus the care and treatment of the youngster born with cleft lip and/or cleft palate is complex, intriguing, long-term, and in this modern day fortunately rewarding.

Congenital Anomalies of the Extremities

JEROME SPIVACK, M.D., Associate, Department of Plastic Surgery, Newark Beth Israel Medical Center; and Clinical Instructor, Department of Plastic Surgery, College of Medicine and Dentistry of New Jersey at Newark

Here will be reviewed some of the common congenital anomalies of the extremities. Illustrative slides will be presented. Various syndromes with extremity anomalies will be discussed. Modes of treatment will be mentioned stressing obtainable improvement in function and appearance. These will be demonstrated with slides. The age when surgery should be performed, the staging of the operative procedures and the possible complications will be mentioned.

Hypospadias

S. DONALD MALTON, M.D., Attending, Department of Plastic and Reconstructive Surgery, Dover General Hospital, Dover

Summary not received

Certain Tumors of Childhood

JOHN C. WALKER, JR. M.D., East Orange; Attending Plastic Surgeon, Saint Barnabas Medical Center, Livingston

The problem of hemangiomas and lymphangiomas in small children will be discussed and illustrated. An attempt will be made to show that there is not one complete answer to this problem. They can be cosmetically very destructive and psychologically very traumatic and each one must be handled

on an individual basis. Great care must be taken in the over-all planning of the surgical and conservative management of these cases. It is hoped that the cases will be accepted by the audience as problem cases and discussed as such.

Special Trauma Considerations in Children

GERHARD PUCHNER, M.D., Attending Plastic and Reconstructive Surgeon, Princeton Hospital

Covered in this presentation are both general and specific considerations with respect to the management of injured children, as well as emphasis on some of the commoner trauma. These include electrical burns of the mouth, facial fractures, foreign body perforations of the palate, wringer injuries, and other conditions.

Plastic Surgery of the Ears

RICHARD B. BLOOMENSTEIN, M.D., Adjunct Attending, Department of Plastic Surgery, St. Joseph's Hospital, Paterson

Plastic and reconstructive surgery of the ear is based on observance of, and if necessary, restoration of the normal anatomy of the external ear. The correction of congenital neoplastic and traumatic deformities of the external ear in children may be associated with serious emotional upset and should be corrected as early as possible.

General Discussion

4:15 p.m. Business Meeting—Election of Officers

4:30 p.m. Visit to Exhibits

CABARET

Saturday, May 15, 1971

Cocktails-Bufferet

Entertainment

The Phi Delta Epsilon Players

Dancing

(Tickets at Registration Desk)

DINNER-DANCE

Monday, May 17, 1971

Entertainment

Dancing

(Tickets at Registration Desk)

1971 Annual Meeting

INFORMATIONAL EXHIBITS

Saturday, May 15—12 noon to 5 p.m.

Sunday, May 16—9 a.m. to 5 p.m.

Monday, 17—9 a.m. to 5 p.m.

Educational Facilities for Emotionally Disturbed Children and Adolescents

MSNJ's Special Committee on Emotional Disorders of Childhood and Adolescence

This exhibit is designed to instruct doctors, especially pediatricians, general practitioners, school physicians (and others concerned with health of children) with the procedures for obtaining special education facilities for emotionally disturbed children and adolescents. Flow charts (showing step by step process) demonstrate methods of diagnosis, selection of the appropriate facility, referral, and follow-up. Two case histories detail actual process. This material is prepared in cooperation with New Jersey State Department of Education.

Children's Specialized Hospital

Westfield-Mountainside

Shown here for the Children's Specialized Hospital are logo and photographs of therapy activities at the hospital.

The Academy of Medicine of New Jersey

Bloomfield, Milton H. Shoshkes, M.D., President

This display describes the activities of the Academy of Medicine of New Jersey in providing continuing education to the physicians of New Jersey.

The Society for the Relief of Widows and Orphans of Medical Men of New Jersey

Belleville, James E. D. Gardam, M.D., President

Here is an information exhibit outlining the aims and purposes of a charitable organization which provides for the health and welfare of widows and orphans of deceased members of the Society.

New Jersey Regional Medical Program

East Orange

The New Jersey Regional Medical Program's involvement in renal disease in New Jersey is explained. Included is a map showing the location of approved New Jersey renal centers, transparencies depicting renal programs and a demonstration of dialysis equipment.

Kate Macy Ladd Convalescent Home

Far Hills

The Kate Macy Ladd Convalescent Home provides a full range of medical services for women recovering from surgery or acute illness, at no cost to the patient.

Disability Insurance Service

New Jersey State Department of Labor and Industry, Trenton

Here explained are the services provided in New Jersey under the Temporary Disability Insurance Law.

New Jersey Health Services Program (Medicaid)

Division of Medical Assistance and Health Services, New Jersey Department of Institutions and Agencies, Trenton

Here offered is an information service booth on Medicaid. In addition to charts, graphs, and slide projections, there will be a professional (physician) and administrative representative, as well as representatives of the contractors, namely, Prudential Insurance Co. and Blue Cross, to field any questions about out state's Medicaid Program.

Epilepsy, the Doctor and the New Jersey Law

MSNJ's Special Committee on Seizures

This unique exhibit has been designed to publicize the new New Jersey law for the edification of the medical profession, about the reporting of epilepsy. This is truly something that every doctor should know.

New Jersey Regional Medical Program

East Orange

This exhibit briefly explains the purpose of the New Jersey Regional Medical Program and describes its operational projects in heart disease, cancer, stroke, renal, and related diseases.

New Jersey Psychological Association

South Orange

The display of the New Jersey Psychological Association is designed to help acquaint the professional and lay public with the functions psychologists perform in New Jersey. From mental health to safety, from public schools to institutions to private practice, from research to clinical practice, psychologists serve the public.

Training of Mental Health Professionals

MSNJ's Council on Mental Health

Described and compared here will be training, functions, and educational backgrounds of the various mental health professional personnel, including psychiatric social workers, psychologists, and psychiatrists.

1971 Annual Meeting

SCIENTIFIC EXHIBITS

Saturday, May 15—12 noon to 5 p.m.

Sunday, May 16—9 a.m. to 5 p.m.

Monday, May 17—9 a.m. to 5 p.m.

X-ray Diagnosis of Interesting Urinary Tract Lesions in a Community Hospital

Willard M. Drake, Jr., M.D., John Pulliam, Jr., M.D., Salvatore Pennisi, M.D., Donald E. Praiss, M.D., Raul Betancourt, M.D., Philip Gilbert, M.D., James P. Harbeson, III, M.D., Kyong Chal, M.D., Felix Oliver, M.D., Vicente Limealco, M.D., Rustico Pollutan, M.D., and Kywoog Kim, M.D., The Cooper Hospital, Camden

Exhibit will illustrate x-rays of: (1) malignancies, (2) congenital anomalies, (3) vascular abnormalities, (4) inflammatory lesions, and (5) traumatic lesions.

Radioactive Gold (Au 198) Abdominal Lymph Node Scintiscanning to Aid in the Evaluation of Abdominal Malignancies

William E. Matthey, M.D., Peter J. Gianquinto, M.D., and James L. Breen, M.D., Saint Barnabas Medical Center, Livingston

This exhibit will demonstrate the usefulness, simplicity, and surgical correlation validity of abdominal lymph node scintiscanning.

The Antiquity of Gout

John H. Talbott, M.D., Chicago

Gout has been recognized as a clinical entity since before the birth of Christ. Many paintings, cartoons, and caricatures on the subject have been produced over the centuries. A representative sample of these form the basis of our exhibit which also presents a brief text on early misconceptions about gout and highlights milestones in its diagnosis and management.

A Regional Network of Pacemaker Clinics

Victor Parsonnet, M.D., Newark Beth Israel Medical Center

The pacemaker center at Newark Beth Israel Medical Center has been setup accurately to predict impending pacemaker failure. The center now has three satellites at other hospitals participating and shortly will have many more.

Computer-Van (Simulated Patient Management)

Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division, Inc.

Interesting cancer cases are programed on a computer. The doctor receives the case history and physical examination by computer print-out. He then diagnoses and treats the patient. He is told whether he is right or wrong and why. Four continuous projection units illustrate various types of cancer. A wide selection of literature is available.

Treatment of the Arthritic Hip

Forrest H. Riordan, III, M.D. and Gino Saliccioli, M.D., Rockford Memorial Hospital, Rockford, Illinois

This exhibit outlines the conservative chemotherapy and physical therapy for the patient with the painful hip due to arthritis. It also outlines the surgical procedures available to the arthritic patient, depending on his age, type of arthritic disease, and the extent of change both in the femoral head and acetabulum.

X-rays and diagrams will here demonstrate the several orthopedic procedures used in treatment of hip disease due to arthritis.

Pentazocine in Orthopedic Pain

David Befeler, M.D., Westfield and Joseph Giattini, M.D., New York

Pentazocine® is an effective, well-tolerated synthetic analgesic which has been proved effective in a variety of clinical pain states. This study demonstrates that Pentazocine® is a safe and useful drug in the management of orthopedic pain in all age groups.

Tuberculosis Treatment in the 1970's

Charles R. Ream, M.D., Chairman, Medical Affairs Committee, Tuberculosis-Respiratory Disease Association of New Jersey, Union

This exhibit covers three areas: (1) An overview of latest recommendations of the National Tuberculosis-Respiratory Disease Association as to the treatment of tuberculosis in the 1970's; (2) A policy statement concerning the treatment of tuberculosis patients in general hospitals adopted by the Tuberculosis-Respiratory Disease Association of New Jersey; and (3) A current affiliate structure of the Tuberculosis-Respiratory Disease Association of New Jersey.

Exchange Transfusions in the Treatment of Hepatic Coma

Maxwell L. Gelfand, M.D., Theodore Cohen, M.D., Burton Speiser, M.D., Allen Aronson, M.D., and Leon Sussman, M.D., New York Infirmary, New York

The mortality rate for hepatic coma that develops during the course of acute hepatic necrosis is extremely high and unpredictable. It is an infrequent event in whatever the treatment used. The clinical course may be identical in survivors and fatalities. The liver has a great capacity for regeneration. In those who survive, both liver cell function and hepatic architecture may return to normal. All such lesions should be regarded as potentially reversible. In managing fulminant hepatitis, it is essential to sustain life long enough for

the liver cell regeneration to occur. To this end, a number of new methods have been suggested to influence recovery. These include (1) Hemodialysis, (2) Cross circulation to human volunteers, (3) Perfusion of the patient's blood through the cooled isolated pig's or baboon's liver, (4) Plasmapheresis, and (5) Exchange transfusions.

Recently, we tried exchange transfusions with success in three patients who were in severe hepatic coma as a result of acute fulminating hepatitis. This exhibit presents these cases. In addition, the world literature on exchange transfusions and the pathogenesis of hepatic coma will be reviewed. Factors precipitating hepatic coma will be emphasized.

Surgical Treatment of Coronary Artery Disease

Joseph J. Timmes, M.D., Nicholas J. Demos, M.D., and Ralph Lev, M.D., New Jersey College of Medicine-Pollak Hospital, Jersey City

With the availability of successful myocardial revascularization utilizing direct shunting from the aorta to the unobstructed residual segments of the coronary arteries, this procedure is now the treatment of choice in selected patients. The anatomy involved, clinical evaluation, indications, contraindications, and surgery performed are here presented.

Kidney Transplantation

Hossein Eslami, M.D., Newark Beth Israel Medical Center

Our aim is to present kidney transplantation as a means available to the patient with end stage renal disease. This exhibit will familiarize practicing physicians with criteria for selection of proper cadaver donors and with the procurement and preservation of the organ.

Tumors of the Breast

Maurice J. Elovitz, M.D., Morton Rosenblatt, M.D., and Edward Rigo, M.D., Atlantic City Hospital

Presented here is a free standing exhibit demonstrating the clinical features of various tumors of the breast. Both benign and malignant diseases are reviewed. Portions of the exhibit are devoted to diagnosis, clinical features, and treatment. Also covered is an outline of surgical and medical therapy as well as the indications and contraindications of specific surgical procedures.

Incomplete Abortion—Early Curettage—Reduced Patient Risk

James L. Breen, M.D., William J. Connolly, M.D., and Caterina A. Gregori, M.D., Saint Barnabas Medical Center, Livingston

Treatment of 1,000 consecutive cases of incomplete abortion (29 per cent septic) demonstrates the benefits of early curettage in controlling hemorrhage and infection. The primary benefits are reduced complication risks. Other benefits also accrue and are discussed.

Prosthetic Limbs and Component Parts—Preparation of a Temporary Prosthesis

Richard A. Sullivan, M.D. and James Tucker, R.P.T., Kessler Institute of Rehabilitation, West Orange

This exhibit is designed to familiarize physicians and paramedical personnel with lower extremity

prosthetic components and with indications for their use. The presentation will display socket, cut away knee joints, ankle and foot assemblies, and temporary prostheses with identification as to parts, indications, and contraindications.

A self-contained film (using a Mark IV viewer) will demonstrate casting procedures for above and below knee sockets for temporary limbs, as carried out at our Institute prior to permanent prosthetic fitting. Polysar X 414 (a thermoplastic material) will be displayed as well as "below knee sockets" which have been made from this material.

"Life Island" Isolation

Milton H. Donaldson, M.D. and Audrey E. Evans, M.D., The Children's Hospital of Philadelphia

Six green 24" by 24" panels will be a background for three large photos and four copy blocks describing the uses for Philadelphia's first double plastic sterile room.

Management of Heart Disease in Children

Milton Prystowsky, M.D., Peter P. Poulos, M.D., Jose R. Antillon, M.D., Nestor Truccone, M.D., Jerome L. Mathias, L.X.T., Alice Forster, R. N. and Joyce Mokrzycki, M.T., Department of Pediatric Cardiology and Division of Cardiovascular Surgery, Children's Hospital, United Hospitals Medical Center; and Department of Pediatrics, College of Medicine and Dentistry of New Jersey at Newark

Demonstrated here is our experience in the evaluation and over-all management of congenital heart disease. Shown is a breakdown in incidence of various congenital heart malformations; methods of evaluation and treatment; presentation of representative cases; types of complications encountered during cardiac catheterization and cineangiography; postoperative complications; and follow-up results of medical and surgical treatment. Our experience demonstrates that with an early and aggressive approach in evaluation and therapy (both medical and surgical), especially in the newborn and infant, we have been able to salvage lives and decrease infant mortality. In many cases, medical therapy is insufficient, and without early surgery, these patients would have died. With open and closed heart surgery we have repaired some congenital heart malformations completely while others have been improved by palliative measures either as a final procedure or in preparation for total correction at a future date. Malformations are also presented for which there is as yet, no known medical or surgical panacea.

Speech Therapy Study

W. Edward McGough, M.D., Maryann Peins, Ph.D., and Bernard S. Lee, B.S., Rutgers Medical School, New Brunswick

A standing screen illustrates a clinical and home-based practice session of a tape recorder therapy for stutterers. Salient conclusions of an Evaluation Experiment are displayed. A showcase cabinet is provided with stereo headsets by means of which visitors can hear a 10-minute demonstration tape. Also displayed are the set of cassette tapes, a therapist's guidebook, and the tape recorders. Rutgers Medical School is providing services to a limited number of speech clinics on a pilot basis in the form of taped programs for stutter therapy and wishes this to be known. Evaluation has shown the tape recorder method to be as effective as other procedures by offering advantages in convenience and economy.

Management of Spina Bifida in a Community Hospital

Martin E. Lasoff, M.D., Morristown Memorial Hospital

Here is a working formula for the diagnosis of spinal birth defects, consultation and total management in a community hospital. The complex problems which may arise are best handled by a multidiscipline team effort. This can be accomplished with great satisfaction to the family and community at substantial savings in time and expense.

Dyslexia

MSNJ's Special Committee on the Conservation of Vision, Hearing, and Speech

Presented here is a three-panel exhibit showing the diagnosis, evaluation, and management of dyslexia.

Chromosome Karyotyping: Community Service and Educational Experience

Medical Students of the College of Medicine and Dentistry of New Jersey-Rutgers Branch, Piscataway

Chromosome karyotyping is being used as a genetics teaching exercise for medical students of the Rutgers branch of the College of Medicine and Dentistry of New Jersey. Students learn the techniques on their own bloods and then work up samples from the resident patients at the Woodbridge Children's Hospital for whom this service had not previously been available.

Pharmacologic Properties and Clinical Effects of Estrogen in the Human

Herbert S. Kupperman, M.D., New York University College of Medicine, New York.

Here is a multi-paneled exhibit showing the phar-

macologic properties and the clinical effects of estrogen.

Fiberendoscopic Diagnosis of Massive Upper Gastrointestinal Bleeding

William I. Wolff, M.D. and Hiromi Shinya, M.D., Beth Israel Medical Center, New York

Fiberoptic flexible endoscopy instruments have been perfected to a degree where they now constitute an important new diagnostic approach. In the Surgical Endoscopy Unit at the Beth Israel Medical Center in New York over 1,500 such examinations have been performed without incident. Fiberoptic esophagoscopy, gastroscopy, and duodenoscopy have been applied extensively in the management of massive upper gastrointestinal hemorrhage, during the acute bleeding phase. The results have been illuminating: these new instruments far surpass any used in the past and the bleeding source can be identified in over 90 per cent of cases in our experience. We have been able to take color photographs and color movies of the findings during examinations, the procedure being done at the bedside, generally in the Intensive Care Unit. In addition to an analysis of the methods and the results, color transparencies of typical pathologic changes and continuous showing of color slides and color ciné studies are part of the exhibit.

Comparative Study of Anxiety with Chloradiazepoxide and Doxepin

C. David Cooper, M.D., George Washington University School of Medicine, Washington

Here described is an evaluation of the efficacy of a benzodiazepine (chloradiazepoxide) and a tricyclic (doxepin) in patients exhibiting moderate to severe symptoms of anxiety. This was done via a double-blind study utilizing a modified BPRS rating scale. Duration of treatment was four weeks. Equal efficacy was shown with both compounds, however, adverse effects occurred more frequently and with more severity with doxepin.

The Medical Society of New Jersey Welcomes the Following Delegates and Guests

American Medical Association	Raymond T. Holden, M.D., Washington, D.C.
Connecticut	E. Tremain Bradley, M.D., Norwalk
Maryland	John F. Schaefer, M.D., Baltimore
New York	Walter Scott Walls, M.D., Buffalo George Himler, M.D., New York
Pennsylvania	William A. Limberger, M.D., West Chester

Please note change in EXHIBIT HALL HOURS

Exhibits open at noon on Saturday and close at 5 p.m. on Monday

TECHNICAL EXHIBITS

Saturday, May 15

Sunday and Monday, May 16 and 17

12 noon to 5 p.m.

9 a.m. to 5 p.m.

In Appreciation

The Medical Society of New Jersey is pleased to recognize, through their generous contributions, the following official patrons of the educational programs presented through the scientific sessions:

Geigy Pharmaceuticals

Johnson & Johnson

The S. E. Massengill Company

Pfizer Pharmaceuticals

The Upjohn Company

American Association of Medical Assistants,
Inc., State of New Jersey Message Center

Distribution of informational brochures describing the aims and purposes of AAMA, its educational opportunities, and certification program. Messages for doctors in attendance at this meeting will be relayed through this booth.

Apache Programs Inc. #25

Apache Programs, Inc. offers limited partnership investment programs for individuals and corporations. These programs are organized and professionally managed by Apache Corporation, an NYSE listed firm. Apache currently operates and manages investment programs in oil and gas exploration, grove land, and real estate. Tax incentives accruing to these programs are passed on to individual investors.

Astra Pharmaceutical Products, Inc. #21

Available will be useful information and descriptive literature pertaining to Xylocaine® (lidocaine) and Citanest® (prilocaine) local and topical anesthetics, and the intravenous use of Xylocaine® in the treatment of life-threatening cardiac arrhythmias.

Ayerst Laboratories #19

Information will be available on Premarin®, Atromid-S®, and Inderal®.

E. & W. Blanksteen Agency, Inc. #11 & #12

E. W. Blanksteen Agency, Inc., are official brokers for The Medical Society of New Jersey for Accident and Health, Major Expense, High Limit Accident, Term Life Insurance, Hospital-Money, HR-10 Keogh Retirement Plan and Corporate Master Retirement Plan.

All these programs provide exceptional value for the members because of the group purchasing power of the State Society.

Joseph A. Britton Agency #10

This is the agency which provides officially endorsed professional liability insurance (all forms).

Coca-Cola USA #48

Ice-cold Coca-Cola will be served.

The Dow Chemical Company #9

Diagnostest® reagents are for clinical chemistries. These have been tested at Bio-Science Laboratories (Van Nuys, California). Reagents are premixed and premeasured into reaction tube. The tube can also serve as the cuvette. All materials needed to perform the test are provided. All tests are colorimetric and can be "read" on any good-quality colorimeter or spectrophotometer. Products are sold "direct" and are serviced by the same representative.

Edison Voicewriter Division, McGraw-Edison Company #46

The Edison Voicewriter Division of the McGraw-Edison Co. sells all types of dictating systems such as portables, dial models, remote control systems, and equipment to record on from outside the office.

Encyclopaedia Britannica, Inc. #18

Encyclopaedia Britannica welcomes delegates to The Medical Society of New Jersey. As part of our exhibit, we will have on display the great new edition of Britannica, Great Books of the Western World, the Britannica Junior, and other related materials. Stop and inspect these products in booth #18. They are available to delegates and members as our convention offer.

Gibraltar Securities Co. #41 & #42

Representatives will be available to discuss securities, land investments, and construction management.

Hoechst Pharmaceutical Company #32

Representatives at booth #32 will be happy to discuss Hoechst products with particular application to the physician's individual practice. Featured are Lasix® (furosemide), Surfact® (Dixidan®), Festal®, and Festalan®.

Lakeside Laboratories, Inc. #23

Lakeside Laboratories, Inc., exhibit will include Cantils®, Imferon®, Mercurydrin®, Metahydrin®, Metatensin®, Norpramin®, and the MedCom Learning System on Depression.

Lederle Laboratories Division, American Cyanamid Co. #2

Representatives will be present to provide information on the pharmaceuticals offered by Lederle—Declomycin® (demeclocycline), Achromycin® (tetracycline), and Aristocort® (triamcinolone).

David & Charles Levinson Medical Specialties #16

Medco-Sonlator Twin: Combination of neuro-muscular stimulation and ultrasound, pulsed, surged, and continuous, synergistically blended. Diagnostic and therapeutic.

Modcotherm: Combination of neuro-muscular stimulation and moist heat thermostatically controlled and blended with soothing reciprocating surge.

Medcolator: Neuro-muscular stimulator with pulse, surge, tetany currents, automatic settings. Model G, combination Medcolator and galvanic current permitting stimulation of denervated muscles and Ion Transfer.

Minalator: Pocket size neuro-muscular stimulator.

Martin Super Automatic Short Wave: New concept in deep heat. Automatic tuning. Push button control.

Eli Lilly and Company #7

You are cordially invited to visit the Lilly exhibit. Representatives in attendance will welcome your questions about our pharmaceutical products. You may be particularly interested in discussing our growing family of cephalosporins.

Marion Laboratories, Inc. #22

Marion Laboratories will have information on Gaviscon®, Pavabid®, and Nitro-Bid®.

Medical-Surgical Plan of New Jersey #31

Visit the Plan's booth and learn why **Prevailing Fee**—the Blue Shield usual, customary, and reasonable fee program—is the "now" program of pre-paid medical care in New Jersey. Why it is good for the patient and good for the physician. How you can support the concept of usual and customary fees vs. a fixed fee schedule—and help **Prevailing Fee** reach its full potential—by signing up to participate.

Medichek, Incorporated #24

Medichek is a new dimension in health care. It is a multi-phasic health screening center that uses automated, computer-based equipment and paramedical personnel to collect biologic data for your evaluation.

Medichek is not a substitute for the traditional physical examination. It is a new entity in the complex of health services. Medichek provides you with the interpretations of a cardiologist, radiologist, ophthalmologist, and pathologist for some tests.

Multiphasic health screening is accepted by the AMA, the American College of Radiology, the American Society of Internal Medicine and the College of American Pathologists.

Merck Sharp & Dohme #8

The Merck Sharp & Dohme exhibit has been designed to offer a contribution to your therapeutic armamentarium. Technically trained personnel are available to discuss the scope and variety of services offered to physicians.

Miller, McGinley & Leader (MONY) #40

Professional Planning Associates is a consulting firm specializing in the financial problems of the professional man. The firm is attending this convention to acquaint interested doctors with the concept of professional incorporation.

National Clinical Services Laboratories, Inc. #35

Our representatives will discuss the clinical laboratory services available to physicians.

New Jersey Bell Telephone Company #13 and #14

Tele-communications services for the medical field will be illustrated and explained at our booths.

Ortho Pharmaceutical Corporation #26

Ortho Pharmaceutical's booth will have a complete line of medically accepted products for the control of conception and the treatment of vaginitis.

Parke, Davis & Company #17

Our representatives will be pleased to discuss selected pharmaceutical products at the Parke-Davis booth.

The Paul Revere Life Insurance Company #49

The Paul Revere offers individual non-cancellable (and guaranteed renewable) disability coverage available at any price. The policy features a definition of total disability which protects you in your specialty to age 55 or for five years, whichever is longer. In addition to many other outstanding features, rates are competitive and qualified physicians may purchase as much as \$3,000 monthly. The New Jersey State Consultants are John Hansbury and J. Mitchell Ehrlich.

PRO Services, Inc. #47

Representatives will have information on the MSNJ approved Professional Association and Keogh Retirement Plan, which is administered by PRO Services, Inc.

Prudential Insurance Company of America
Coffee Lounge

The Prudential is the carrier for Medicare Part B and intermediary for certain facilities for Part A in New Jersey. It is the contractor for Physicians' Services for New Jersey Medicaid and same facilities as in Medicare.

A. H. Robins Company #1

You are cordially invited to visit the A. H. Robins display and meet our representatives who will discuss with you products of interest. Our most recent new product release is Dimacol™ (pseudoephedrine, pheniramine, dextromethorphan and glyceryl guaiacolate).

Roche Clinical Laboratories #50 & #51

With the establishment of Roche Clinical Laboratories, Roche introduces a new parameter in its commitment to better health care. Roche Clinical Laboratories embodies current concepts in diagnostic testing, designed to provide top quality clinical and endocrine laboratory services for the patient, the physician and the hospital laboratory. The clinical laboratory/diagnostic staff includes a full complement of pathologists, endocrinologists, medical technologists, laboratory technicians, computer scientists, professional representatives, and administrative personnel.

William H. Rorer, Inc. #20

William H. Rorer, Inc. takes pride in exhibiting its fine pharmaceutical products at this convention. Our representatives will gladly discuss Maalox®, Camalox®, Ascriptin®, Quaalude®, and our other products with you.

John J. Ryan & Co. #39

Our representatives will be available to discuss tax-exempt municipal bonds and New Jersey bank stocks.

Sandoz Pharmaceuticals #29

Information will be available on Serenitil® and Mel-laril®.

W. B. Saunders Company #30

Saunders will have on display a complete line of their medical books, including many new titles and new editions published since last year's meeting.

Schering Laboratories #28

Schering Laboratories invites you to visit their exhibit where representatives will be available to discuss with you any questions you may have on Garamycin® Injectable, Etrafon®, Valisone®, Dri-xoral®, Celestone®, Soluspan® Injection, Afrin®, or any other Schering product.

G. D. Searle & Co. #56

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be information on Demulen®, Enovid®, Aldactazide®, Flagyl®, Lomotil®, Pro-Banthine®, and other drugs of interest.

E. R. Squibb & Sons, Inc. #15

E. R. Squibb and Sons, Inc. are pleased to present a film review of "up-to-date" and factual reports on current topics of medical interest and research. They include such topics as "Drug Abuse," "Aerospace Medicine," and "Heart Transplantation."

This series of short films may be seen in our booth at anytime during the convention hours.

Stuart Pharmaceuticals, Division of Atlas Chemical Co., Inc. #52

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Pharmaceutical booth. Specially trained representatives will be in attendance to answer your questions on new products, developed in our modern laboratories, which have particular interest for the medical profession. Products featured are: Dialose®, Dialose® Plus, Mulvidren®, Mylanta®, Mylicon®, Stuart Prenatal®, Stuart Prenatal® w/Folic Acid, Sorbitrate®, and our new products: Probec-T® and Kinesed®.

44th ANNUAL MEETING

Woman's Auxiliary to The Medical Society of New Jersey

Saturday through Tuesday
May 15-18, 1971

Chalfonte-Haddon Hall
Atlantic City

Schedule of Events

Saturday, May 15, 1971

10:00 a.m. to 4:30 p.m.—Sale of dinner-dance tickets

MSNJ Registration Desk
(Exhibit Hall, Lobby floor, Haddon Hall)

12:00 noon to 4:30 p.m.—Registration
(Exhibit Hall, Lobby floor, Haddon Hall)

1:00 p.m. to 4:30 p.m.—Registration for Art Show
(Exhibit Hall, Lobby floor, Haddon Hall)

*1:00 p.m.—Golden Merit Award Ceremony
(Rutland Room, First floor, Haddon Hall)

*3:00 p.m.—Auxiliary President's Report to MSNJ
House of Delegates
(Windsor Room, Haddon Hall)

*7:00 p.m.—Reception-Buffer Dinner
Honoring Technical Exhibitors
A special invitation is extended to
Auxiliary members (tickets may be
purchased at MSNJ Registration Desk
—\$12.00 per person)
(Carolina Room, First Floor,
Chalfonte)

Sunday, May 16, 1971

9:30 a.m. to 4:30 p.m.—Registration
(Exhibit Hall, Lobby floor, Haddon Hall)
Tickets for Tea and Fashion Show

10 a.m. to 4:30 p.m.—Sale of dinner-dance tickets
MSNJ Registration Desk
(Exhibit Hall, Lobby floor, Haddon Hall)

10:00 a.m.—Art Exhibit
County Press and Publicity Books
Exhibit
County Activities Pictorial Display
(Exhibit Hall, Lobby floor, Haddon Hall)

10:00 a.m.—Pre-convention Board Meeting
(Navajo Room, 15th floor, Haddon Hall)

12:00 noon—Fellowettes' Luncheon
(Blue Room, Office floor, Chalfonte)

2:30 p.m.—Tea and Fashion Show
(Vernon Room, Lounge floor, Haddon Hall)
All doctors' wives and guests cordially invited

*6:00 p.m.—Reception for President-elect Davis
Auxiliary members are cordially invited to attend (Admission by badge)
(Pennsylvania Room I, Lounge floor, Haddon Hall)

Monday, May 17, 1971

8:15 a.m. to 4:30 p.m.—Registration
(Exhibit Hall, Lobby floor, Haddon Hall)

8:15 a.m. to 9:00 a.m.—Continental Breakfast
(Hallway, 13th floor, Haddon Hall)

9:00 a.m. to 12:30 p.m.—General Session
(West Room, 13th floor, Haddon Hall)

9:00 a.m. to 4:30 p.m.—Sale of dinner-dance tickets
MSNJ Registration Desk
(Exhibit Hall, Lobby floor, Haddon Hall)

1:00 p.m.—Annual President's Luncheon
(Pennsylvania Room III, Lounge floor, Haddon Hall)
All doctors' wives cordially invited

*7:00 p.m.—Dinner-Dance
(Pennsylvania Room, Lounge floor, Haddon Hall)

Tuesday, May 18, 1971

8:30 a.m.—Workshop for County Presidents
(Suite 609, Haddon Hall)

9:00 a.m. to 12:00 noon—Registration
(Exhibit Hall, Lobby floor, Haddon Hall)

11:30 a.m.—Post-convention Board Meeting
(West Room, 13th floor, Haddon Hall)

Convention Committee

Chairman—Mrs. Charles Gandek
Co-Chairman—Mrs. Louis Abbamonte

*MSNJ events to which Auxiliary members are cordially invited.

ROOM RESERVATIONS

Complete and mail this form for your room reservation

205th ANNUAL MEETING—THE MEDICAL SOCIETY OF NEW JERSEY
May 15-18, 1971

Reservation Desk, Chalfonte-Haddon Hall, Atlantic City, New Jersey

Please Reserve the Following Accommodations—This Reservation Will Be Acknowledged
If room is not available at rate requested, please check here
authorizing us to make reservation at next available rate. ☐

No. of Rooms	HADDON HALL	All Rooms Air Conditioned	CHALFONTE	All Rooms Air Conditioned
	Single, Bath, 1 Person	Twin Bedroom, Bath 2 Persons	Single, Bath 1 Person	Twin Bedroom, Bath 2 Persons
	Without Ocean View <input type="checkbox"/> 17 <input type="checkbox"/> 19 <input type="checkbox"/> 21	* <input type="checkbox"/> 21 <input type="checkbox"/> 23 <input type="checkbox"/> 25	<input type="checkbox"/> 16 <input type="checkbox"/> 19	<input type="checkbox"/> 20 <input type="checkbox"/> 23
	Side Ocean View <input type="checkbox"/> 25 <input type="checkbox"/> 27	<input type="checkbox"/> 27 <input type="checkbox"/> 29 <input type="checkbox"/> 31	<input type="checkbox"/> 22	<input type="checkbox"/> 25 <input type="checkbox"/> 27
	Ocean Front <input type="checkbox"/> 36	<input type="checkbox"/> 36 <input type="checkbox"/> 38	<input type="checkbox"/> 25 <input type="checkbox"/> 26	<input type="checkbox"/> 28 <input type="checkbox"/> 29 <input type="checkbox"/> 32
	Double & Parlor	<input type="checkbox"/> 52 <input type="checkbox"/> 62 <input type="checkbox"/> 64		
	Double & Parlor Ocean Front	<input type="checkbox"/> 80		<input type="checkbox"/> 68

EACH ADDITIONAL PERSON IN DOUBLE ROOM \$5.00 EUROPEAN PLAN *Roomettes
MODIFIED AMERICAN PLAN (BREAKFAST & DINNER) ADD \$9.00 PER DAY, PER PERSON ☐

I will share a room with

Day and date of arrival Departure

Name

Address
PLEASE PRINT Plus 5% City Tax

NOTE: As check-out hour is 2:00 p.m., rooms may not be ready earlier.

COMMITTEE ON ANNUAL MEETING

JAMES A. ROGERS, M.D., Chairman, East Orange

ARTHUR BERNSTEIN, M.D.,
Vice-Chairman, Maplewood

NICHOLAS A. BERTHA, M.D., Wharton

DONALD C. DAVIDSON, M.D., Atlantic City

JEROME G. KAUFMAN, M.D., East Orange

ROBERT E. VERDON, M.D., Cliffside Park

LOUIS F. ALBRIGHT, M.D., Ex-Officio, Spring Lake

MRS. MARION R. WALTON,
Convention Manager, Trenton

SUBCOMMITTEE ON SCIENTIFIC EXHIBITS

ARTHUR BERNSTEIN, M.D., Chairman, Maplewood

H. IRVING DUNN, M.D., Bay Head

ARTHUR KROSNICK, M.D., Trenton

JOHN J. THOMPSON, M.D., Caldwell

ROBERT E. VERDON, M.D., Cliffside Park

SUBCOMMITTEE ON SCIENTIFIC PROGRAM

JAMES A. ROGERS, M.D., Chairman
Paterson

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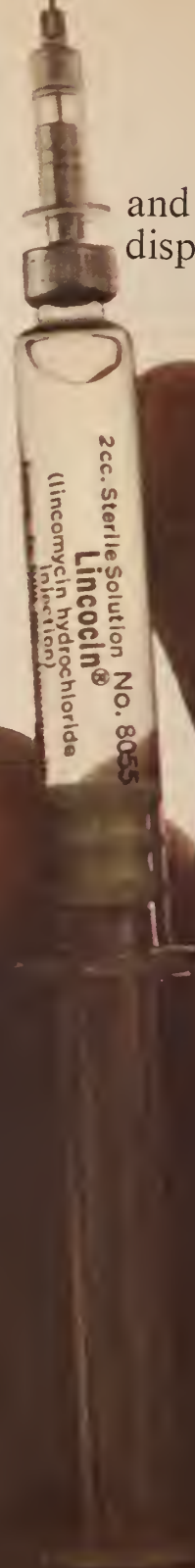
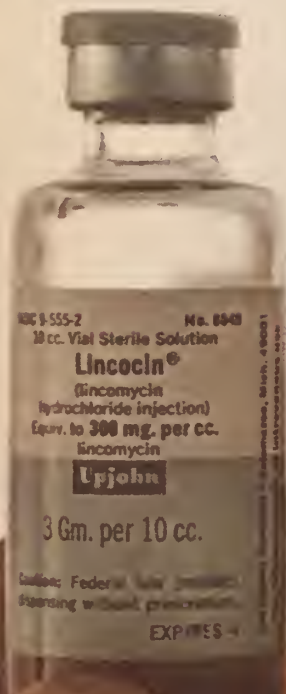
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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

February 21, 1971

A regular meeting of the Board of Trustees was held on February 21, 1971 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Louis Stanley Wegryn, M.D. . . . Adopted the following memorial resolution and authorized a \$50 contribution to the Medical Student Loan Fund in memory of Dr. Louis S. Wegryn, 170th President of The Medical Society of New Jersey, who died on February 14, 1971:

LOUIS STANLEY WEGRYN, M.D.

1903-1971

Whereas, Almighty God has summoned from our midst His good servant and our beloved colleague, Louis Stanley Wegryn, M.D.; and

Whereas, in his long career as a surgeon of high competence, Doctor Wegryn distinguished himself as one who loved and served his fellowman; and

Whereas, with exemplary and unselfish devotion throughout his entire career, he championed the ideals and humanitarian goals of the medical profession and served well The Medical Society of New Jersey as a faithful member and able President; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of the Board and that another copy, suitably prepared, be presented to Doctor Wegryn's bereaved family in token of heartfelt sympathy.

Senate Bill 2083 . . . Voted to approve S-2083, which would admit to State Board examinations those graduates of foreign medical schools who "have completed a full year of intern training in a medical college hospital or a hospital affiliated or associated with such medical college." Previously, foreign medical graduates have been required to present evidence of a license to practice in that foreign country, or to have served "no less than three

full years of postgraduate, intern, or resident training in a hospital in the United States approved by the Board." Basic purpose of S-2083 is to eliminate the discriminatory effect that current requirements impose upon American citizens who are graduated from foreign schools, but the effect is to equate all foreign medical schools with those in the United States and Canada.

Assembly Bill 2131 . . . Recorded itself as taking a position of "no action" on A-2131 because its provision (to discontinue observance and enforcement by New Jersey hospitals of the regulations promulgated by the Educational Council for Foreign Medical Graduates) might precipitate a crisis that would result in the withdrawal by the AMA Council on Medical Education of approval of all postgraduate medical training programs (internships and residencies) in New Jersey.

. . . Directed that the Society's position on S-2083 and on A-2131 be forwarded to the Governor.

College of Medicine and Dentistry of New Jersey . . . Concurred in the action of the Executive Committee (upon recommendation of the Committee on Medical Education) in presenting to the Acting Chairman of the Board of Trustees of the College of Medicine and Dentistry of New Jersey a statement reaffirming the following recommendations taken by the 1970 House of Delegates:

1. That the existing full medical program and facilities at Newark be maintained and expanded as planned.
2. That the present College of Medicine facility at Rutgers be maintained and enlarged to accommodate 100 students per class under a *complete* M.D. degree program, as soon as possible.
3. That a third full-degree-program school in Southern New Jersey be brought into being as soon as feasible.

Note: The above action was the result of a communication from the Mayor of Newark

suggesting changes in the planned medical complex in Newark which has been approved by HEW and for which HEW has granted 35 million dollars (to be matched by New Jersey). Any alterations in the Plan, at this time, will effect an HEW withdrawal of the grant.

Definition of "Active Practice of Medicine"

. . . Concurred in the following statement to the Camden County Medical Society from the Secretary of the Society concerning a definition of the "active practice of medicine" as it is used in Article IV, Section 6, of the Constitution of MSNJ, dealing with emeritus members:

"The active practice of medicine consists of the earning of one's livelihood by the performance of such work and the rendering of such services as require the knowledge and/or skills proper only to members of the medical profession."

Conference of County Society Presidents . . .

Approved a request to schedule the spring conference of Presidents and Presidents-Elect of component societies in conjunction with the March 21 meeting of the Board.

Carrier Clinic Program . . . Agreed to co-sponsor, without expense to the MSNJ, the Carrier Clinic Foundation program of continuing education to members of the District Branch of the American Psychiatric Association.

Task Forces on Health and Mental Health and on Nutrition . . . Named John R. Rush-ton, III, M.D. of Camden to serve on the White House Conference on Aging (November-December 1971), Task Force on Health and Mental Health, and Harvey P. Einhorn, M.D. of South Orange on the Task Force on Nutrition.

AMA-AMPAC Public Affairs Workshop . . .

Authorized the following MSNJ official representative to the AMA-AMPAC Public Affairs Workshop to be held March 13 and 14 in Washington, D.C.: President, President-Elect, Second Vice President, and the Executive Director.

AMA Conference of Medicolegal Committees of Medical Societies . . . Designated the Chairman of the Committee on Medical Defense and Insurance, William J. D'Elia, M.D., to represent MSNJ at the AMA Conference for representatives of Medicolegal Committees of Medical Societies, March 17 and 18 in New York.

AMA Council on Environmental and Public Health . . . Authorized the Chairman of the Committee on Environmental Health, Roslyn Barbash, M.D., to attend the meeting of the AMA Council on Environmental Health, April 25 in New York.

Relative Value Index . . . Approved the following recommendation of the Council on Medical Services:

That The Medical Society of New Jersey adopt—as its updated version—the Fifth Edition (1970) Relative Value Studies of the California Medical Association.

Committee on Child Health . . . Approved, as amended by the Board, the following recommendation from the Committee on Child Health, which had been concurred in by the Council on Public Health:

That members of The Medical Society of New Jersey be encouraged to become more involved in the Child Study Teams in their district and critically inspect the use and misuse of drugs for school children with problems in learning and behavior.

Eye Health Screening Program . . . Disapproved the following recommendation from the Council on Public Health and directed that the present name and purpose of the Eye Health Screening Program be continued:

That the Special Committee on the Conservation of Vision, Hearing, and Speech be authorized to poll by mail all of the member ophthalmologists of the New Jersey Academy of Ophthalmology and Otolaryngology requesting their opinion on changing the format from the Eye Health Screening Program to screening solely for "Glaucoma Detection."

Dyslexia Exhibit at NJEA Convention . . . Approved the following recommendation of the Council on Public Health, as proposed by the Committee on Conservation of Vision, Hearing, and Speech:

That the dyslexia exhibit again be presented and financed by MSNJ and that an invitation be extended to other specialty groups, such as the Pediatricians, Nurses' Association, the Commission for the Blind, and the New Jersey Academy of Ophthalmology and Otolaryngology to participate in this health display at the New Jersey Education Association Convention in 1971.

Dyslexia Exhibit at MSNJ Annual Meeting . . . Authorized the expenditure of up to \$200 for presentation by the Committee on Conservation of Vision, Hearing, and Speech of a scientific exhibit on dyslexia at the MSNJ Annual Meeting.

MSNJ Official Statement on Dyslexia . . . Approved the following recommendation of the Council on Public Health, as proposed by the Committee on Conservation of Vision, Hearing, and Speech:

That in view of the increased problem of dyslexia, the Committee on the Conservation of Vision, Hearing, and Speech be authorized to reissue the policy statement on dyslexia and that the previous distribution be repeated this year.

Australia Antigen Screening of Blood Units . . . Directed that Dr. Martin Goldfield, Director, Division of Laboratories, New Jersey Department of Health, be requested to send a letter, to all blood bank directors who received his original memo of August 5, 1970 (which suggested that "should it be necessary to use untested units . . . pints be taken . . . from donors who have contributed other units . . . that have been tested and reported as being Australia antigen negative"), similar to the one received by MSNJ which stated in part that: "There were no prohibitions of any sort although it appears that some few may have interpreted the third paragraph of the memorandum as such. In view of the present nationwide sensitivity on the part of blood banks to medico-legal aspects of hepatitis, it is understandable that some blood bank directors may have decided that it was appropriate to take an ultra-conservative approach toward dispensing blood not tested for HAA. Obviously in emergency situations where fresh, whole blood is the indicated form of therapy one cannot stand on formalities even when faced by medico-legal considerations. In such situations the decision to use

unscreened blood must be made by the physician as a calculated medical risk. A statement concerning the circumstances should be placed on the patient's chart and it would be wise for the blood bank to have some sort of record in its files."

Medical Defense and Insurance . . . Approved the following recommendation of the Committee on Medical Defense and Insurance:

After detailed study and deliberation of the proposed rate increase of 48.5 per cent and the extensive statistical data relevant thereto, the Committee on Medical Defense and Insurance concluded that they have neither the comprehensive understanding nor the expertise necessary to recommend either that the Society approve or disapprove the proposed rate increase at this time. They recommend that the Board of Trustees so inform Employers Insurance of Wausau and indicate to that Company that the Society will defer final action on the proposed rate increase until the Department of Insurance of the State of New Jersey has dealt with it.

Medical Manpower—Physicians' Associates . . . Approved the following recommendations of the Committee on Medical Education concerning the establishment of a department of community medicine at CMDNJR:

1. That The Medical Society of New Jersey endorse in principle the Proposed Department of Community Medicine, and the Baccalaureate Program for Physicians' Associates as drawn up by Richard J. Cross, M.D., Chairman of the Department of Medicine at the College of Medicine and Dentistry of New Jersey at Rutgers.

2. That the Board of Trustees supply Dr. Cross with the names of 5 or 6 representatives of the Society that he may select from to serve on the Community Medicine Advisory Council.

. . . Directed that the President be empowered so select suitable candidates as requested in the above recommendation.

Emergency Medical Care Exercise . . . Approved a recommendation from the Committee on Emergency Medical Care that the State-wide Emergency Medical Care Exercise and format be approved. (Cosponsorship of this exercise was previously approved by the Board at its meeting on May 15, 1970.)

Position Statement on Emergency Medical Care . . . Approved the following recommendation of the Committee on Emergency Medi-

cal Care: (Position statement referred to was approved at the December 20th meeting of the Board of Trustees)

That the Board of Trustees approve the dissemination of the position statement on emergency medical care to each state medical society with the request that similar action be taken.

Board of Medical Examiners . . . Directed that the following names be forwarded to the Governor as candidates for the Board of Medical Examiners to fill the term of Irving R. Hayman, M.D. which will expire on March 13, 1971:

Irving R. Hayman, M.D., Paterson
Arthur Bernstein, M.D., Maplewood
Nicholas A. Bertha, M.D., Wharton
Joseph R. Jehl, M.D., Clifton

Health Facilities Planning Council . . . Received, as informative, a communication from the President of the Board of Trustees of the Health Facilities Planning Council stating that the activities of the Council were terminated as of December 31, 1970.

Stimulating Athletes With Drugs

Dr. Max Novich, a member of our Middlesex County Medical Society, has just published *The Training and Conditioning of Athletes* (Lea and Febiger)—see page 349 of this issue for detailed review. At a press conference on the subject, he discussed abuse of narcotics and stimulants in an effort to pep up or quiet down the jittery athlete. "Some paramedical personnel," he explained, "use pills, pain killers, and injections surreptitiously and without general professional knowledge. Some trainers of athletic teams give out drugs, narcotics, and stimulants without understanding the physiological responses and after-effects when they administer these to athletes. They don't have any idea of the harm that can result."

He added, too, that people in training rooms have access to narcotics and stimulants, often supplied by drug companies. "This way of life in athletics," Dr. Novich said, "starts in the colleges and is routine by the time the ballplayer is a professional. The training room has vitamin pills, and the athletes get used to stuffing anything into their mouths. They take pills to cut down on breathing, to supply energy, to give them pep—anything. The ultimate danger is that the athletes are not aware of the fact that amphetamine is not Vitamin C. Steroids are not made for careless consumption. They will increase the body size, but should be taken only by prescription of a doctor. The indiscriminate consumption of steroids is dangerous, as is the unsupervised use of all drugs and stimulants."

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during February 1971:

	1971 February	1970 February
Aseptic meningitis	3	8
Primary encephalitis	0	1
Hepatitis: Total	327	87
Infectious	264	69
Serum	63	18
Malaria: Military	5	6
Meningococcal meningitis	5	10
Mumps	273	333
German measles	37	86
Measles	50	212
Salmonella	54	34
Shigella	30	10

Influenza Type B

After reaching a peak in the first week of February, influenza activity in New Jersey has declined during the latter part of the month. Elementary and junior high schools were affected primarily by the outbreaks. No reports of excessive industrial absenteeism were received. One college campus reported an unusual incidence of upper respiratory ill-

ness during February. Influenza type B was confirmed by the State Virology Laboratory either by isolation of virus from pharyngeal washes or diagnostic antibody titer rises in paired acute and convalescent serum specimens from selected outbreaks in all regions of the State.

Malaria—1970

New malaria cases reported to the New Jersey State Department of Health decreased from 151 in 1969 to 59 during 1970. This represents the lowest number of malaria cases reported since military activities were intensified in Southeast Asia during 1967. All of the cases reported (plus an additional 26 relapses) occurred in male military personnel or recently discharged veterans who had served in the Republic of Viet Nam. The absence of civilian cases in 1970 stands in contrast to the five that occurred among civilians in 1969, all of whom had a history of recent overseas travel to malarious areas.

The onsets of the reported cases occurred randomly throughout the year, probably reflecting changes in military personnel assignments rather than a seasonal proclivity. All but five of the 1970 cases occurred in persons who were between 19 and 25 years of age, and no deaths were reported. Only 40 per cent of the patients gave a history of taking anti-malarial drugs prophylactically prior to the onset of their illness. *Plasmodium vivax* was responsible for 76 per cent of the new cases, while *plasmodium falciparum* accounted for 17 per cent. There was only one case due to *plasmodium malariae*, and the species was unknown in the remaining three (5 per cent).

The rapidity of present day air travel emphasizes the necessity of obtaining a good travel history in patients with unexplained febrile illnesses, especially among young adults who may have served either with the Armed Forces in Southeast Asia or as Peace Corps volunteers. If the doctor thinks of it, the diagnosis will be confirmed by the examination of appropriate blood smears for malarial parasites, and antimalarial therapy can be initiated.

New Teaching Hospital For Rutgers Medical School

Medical education at Rutgers took a leap forward at the end of 1970, when the State leased Raritan Valley Hospital as a clinical facility for Rutgers. This hospital is in Somerset County, seven miles from the University Heights Campus in Piscataway. The three-story hospital can accommodate 128 patients. It was constructed in 1965 and has been used as a community hospital since then. Headquarters of the medical school is at this campus, where the Rutgers Science Center has been developing for more than twenty years.

Dr. James W. Mackenzie, Chairman of the Rutgers Department of Surgery, said no major structural changes are contemplated for patient care areas at the hospital. He pointed out that addition of wings containing laboratories, offices, outpatient facility, and lecture rooms will be the principal changes.

In addition to the clinical departments now in the medical school, there will be departments established in pediatrics, obstetrics, and radiology. Conversion of the hospital for teaching purposes is expected to take about 18 months. By September, 1972, it will be ready to accommodate 32 of the current class of 80 first-year medical students. These will be the first to enter third-year clinical studies without transferring to another institution. By June 1974, they should complete the clinical requirement for the M.D. degree.

Because the capacity of Raritan Valley Hospital will accommodate fewer than half the 80 members of an entering class, the Board of Trustees of the College of Medicine and Dentistry of New Jersey and the Rutgers Medical School staff are exploring various alternatives to provide other clinical education facilities to handle the rest of the class.

Possibilities being considered include expansion of Raritan Valley Hospital, affiliations with other area hospitals, and erection of a teaching hospital near the medical school.

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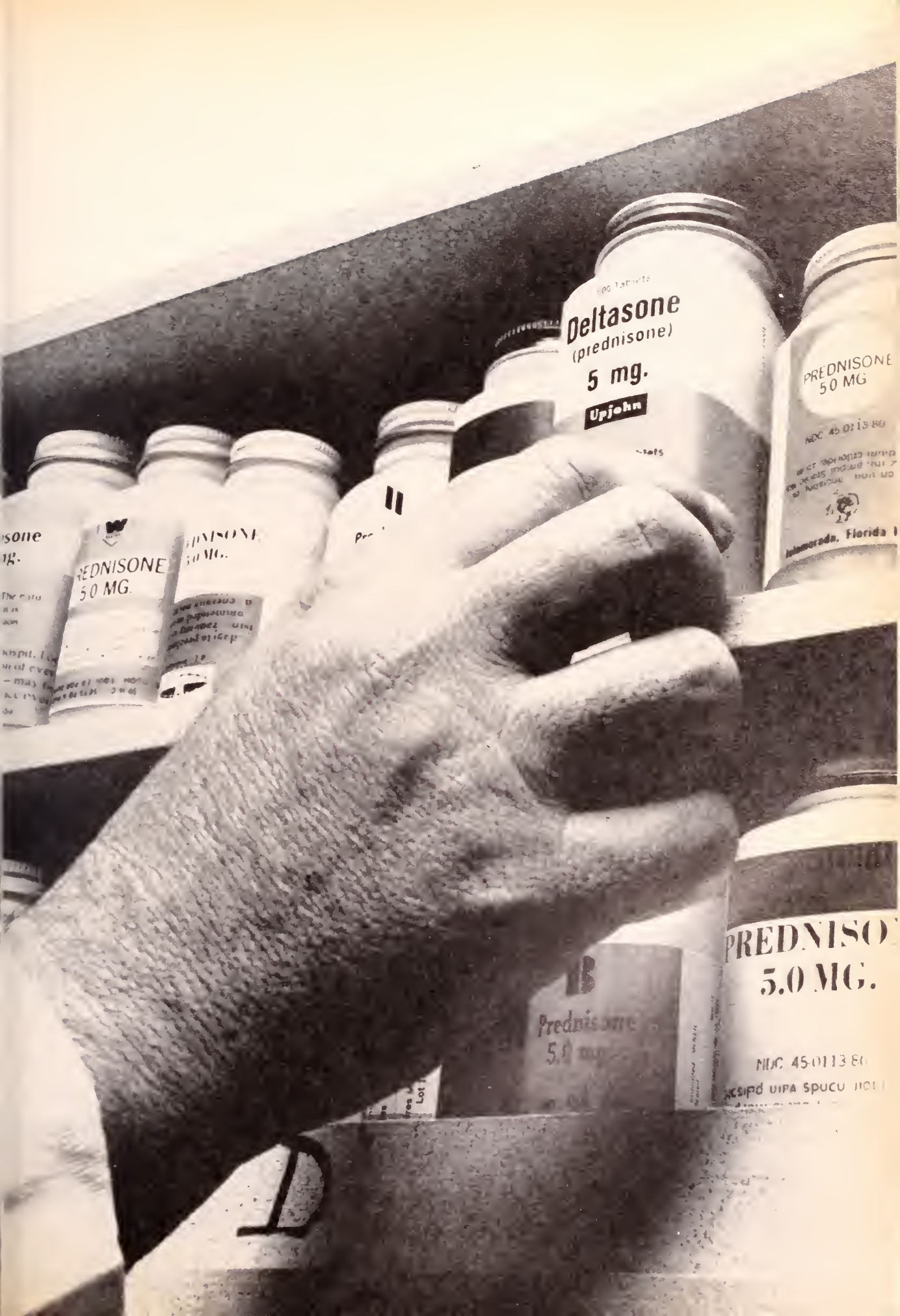
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Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. **Important:** Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. **Considered Absolute**—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. **Considered Relative**—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective mainte-

nance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9- α -fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoid during pregnancy, since spontaneous remission of some disease, such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis an ulcer regimen and antacid are highly recommended. Take X-ray in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

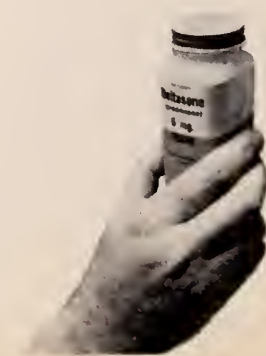
Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., scored—bottles of 100 and 500 tablets and cartons of 100 tablets in foil strips.

For additional product information, consult the package insert or see your Upjohn representative.

MED B-15 (KGB)

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001



**Deltasone® 5 mg.
(prednisone, Upjohn)**

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prednisone
that's made
a name for itself**

Family Doctor and Medicare

A recent survey shows that U.S. family doctors have increased their incomes since Medicare and Medicaid began in 1966, by 25 per cent for the highest ratio of increase group. At the same time, this group (working an average of 59 hours per week in 1965) increased the number of hours worked by 15 per cent and the number of patient visits by the same percentage.

The survey results reflect income and related practice data of 1,000 members of the American Academy of General Practice. Respondents represent an at-random cross section of the United States. Purpose of the survey was to find out how much family doctors had benefited financially from the two big federal health programs.

A recent national publication had suggested there had been increases in earnings of as high as 71 per cent since Medicare. This survey does show a rise in net earnings in all groups (categorized by hours worked per week), but these percentage increases range from 5 per cent for doctors working 41 to 45 hours per week, to 26.3 per cent for doctors who work 66 to 70 hours per week. Doctors working over 70 hours per week increased their earnings by only 18 per cent. The highest percentage-increase-group of doctors, which had an average before-tax income of \$36,454 a year in 1969, actually increased its net earnings per patient visit by only 30 cents between 1965 and 1970.

While number of hours worked per week and number of patient visits per week have gone up considerably for many of these doctors, the time spent per patient visit has remained about the same. For example, the number of patients seen per hour is three and a fraction in all categories now, and was just about the same in 1965. These data indicate approximately 18 minutes per patient visit in all categories.

The survey did show that all respondents had at least a small increase (5 per cent or less) in net earnings as a result of Medicare

and Medicaid. This tends to support the contention of many doctors that they now are being paid for the services that they rendered free of charge before the federal programs came into existence. This payment, thus, became primarily net profit because costs already were factored in for patients not previously charged for service who later became Medicare patients.

Eighty-one per cent of all respondents live and practice in towns larger than 5,000, and 33 per cent of them live and practice in cities of over 1,00,000 population.

Just under 60 per cent of doctors who work less than 40 hours per week practice in towns of less than 25,000. By contrast, less than 10 per cent of the small number of respondents (28) work less than 40 hours work in towns of more than 100,000. At the same time, the survey shows that more doctors in towns of 5,000-25,000 worked more than 61 hours per week than did doctors in any other community-size category. In other words, it would appear that rural and small-town doctors do not necessarily, according to this survey anyway, appear to be any more overworked than doctors in larger centers.

Respondents report that 39.5 per cent of all those in group practice work more than a 60-hour week. At the same time, only 44.6 per cent of solo practitioners, long held by many medical circles to be the most overworked and harried of all U.S. doctors, worked more than 60 hours a week.

The most significant general conclusion from the survey would appear to be that the more a doctor works, the more he can earn, but not in direct ratio to additional hours worked. This is illustrated by the net increase in earnings per patient visit since 1965. For all doctors working between 41 and 65 hours per week, this increase is stabilized at an average of about 44 cents. It drops off sharply to 30 cents in the 66 to 70 hour-per-week group, and plummets to a 14 cent increase per patient visit for the more than 70 hour-per-week group.



decision:

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Cephaloridine

1.5 to 3 Gm. daily
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 - pneumonia
 - urinary tract infections
 - septicemia
 - abscesses
- broad-spectrum activity
- relatively painless I.M. injection

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



000904

Loridine[®]
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

Loridine® CEPHALORIDINE



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems

to be greater in seriously ill

patients given more than recom-

mended doses. Acute tubular

necrosis has been found in affect-

ed patients coming to autopsy. Rare

cases of nausea and vomiting have

occurred. Pain in association with in-

tramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information
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Lilly

International Health Statistics Questioned

The President of the American Medical Association has challenged the conclusion often drawn from international vital statistics which seem to indicate that the United States lags behind a dozen other nations in quality of health care. Source of the statistics on such areas as infant mortality and other deaths is the United Nation's Demographic Yearbook, published annually by the world body.

"What gets overlooked," says Dr. Bornemeier, "is the introductory chapter. This chapter points out the impossibility of drawing meaningful comparisons among nations from the data collected. The figures fall prey to variables such as social conditions and population groups which differ among countries."

Dr. Bornemeier cited as an example the definition of a live birth. In the United States, it generally means any sign of life: a heart beat, movement of voluntary muscles, or even pulsation of the umbilical cord. In some countries, a birth—and therefore, an infant death—isn't recorded if the infant doesn't draw a breath, or, in some cases, if it dies before its birth is registered some days later. Thus, an infant who doesn't survive the critical early hours of life would be reported as an infant mortality in the United States, but would never even be counted in the population of some other countries.

The AMA President suggests that infant mortality is not a good indicator of the health status of a nation. Mortality rates from selected diseases show wide national variations. It is necessary to look at the complete record of a nation's health to draw meaningful conclusion.

An indication of the progress already achieved comes from preliminary figures just released by the Metropolitan Life Insurance Company, which stakes its financial success in good measure on the soundness of its mortality statistics. Infant mortality rates, at a low of

21 per 1,000 live births in 1969, may drop to less than 20 per 1,000 live births in the United States for 1970, the company reports. The rate has been trimmed 25 per cent in the decade just ended, compared with a drop of 11 per cent in the decade before. That still leaves the question of why infant mortality rates seem even lower in nations such as the Scandinavian countries, The Netherlands, and Japan. Aside from national differences in what the statistics mean, the answers lie in a comparison of social, environmental, and other factors affecting the populations of various countries.

Unlike the homogenous population of countries such as those of Scandinavia, the American population includes a vast spectrum of national backgrounds, races, cultural strata, and economic levels. A segment most accurately classified as culturally deprived or poor contributes heavily to United States' infant mortality. This group has no equivalent in most of the countries which appear to lead in infant mortality. Coupled with this is the matter of differing national attitudes toward sex, abortion, and the prevention of unwanted pregnancies. "In many of those countries with low infant mortality," said Dr. Bornemeier, "almost every baby born is a wanted baby. In Japan, for example, there is abortion upon demand."

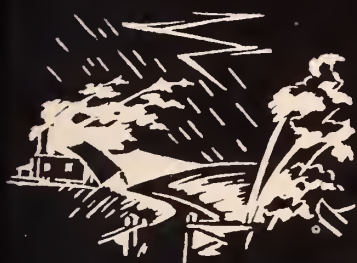
New Names For Our Medical Schools

The Trustees have renamed the complex at Newark and it will be called the College of Medicine and Dentistry of New Jersey at Newark (with new initials CMDNJN). The school at New Brunswick will be called the College of Medicine and Dentistry of New Jersey at Rutgers (with new initials CMDNJR). The Board says the new names will "reflect the concept that the geographically separated medical education facilities comprise two campuses of a single institution." The two schools will continue to recognize their separate origins and identities.

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Sunday
From
2 p.m.



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BLACK HORSE PIKE
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Hurricane Camille dumped up to 31 inches of rain on Virginia's Blue Ridge Mountains the night of August 19-20, 1969. She had already devastated the Gulf Coast from Louisiana to Florida, halted her northward journey over Kentucky and Tennessee, then headed eastward over West Virginia and Virginia.

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EACH TABLET OR CAPSULE CONTAINS:

Phenobarbital 16 mg.

(Warning: may be habit-forming)

Bensulfoid (See PDR) 65 mg.

Precaution: same as 16 mg. phenobarbital

DOSAGE: One tablet or capsule every 6 hours will sustain mild sedation.

Available in three forms to satisfy prescribing circumstances:

TABLETS	100s	500s	5000s
CAPSULES	100s	500s	1000s
TABLETS S/C	100s	500s	4000s

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PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Mario I. Veluz, M.D., 128 Beatty Circle, P.O. Box 144, Westville, Indiana 46391. Manila Central University 1949. Board eligible. Group, partnership, solo. Available.

Pankaj V. Master, M.D., 88 Fallbrook Bay, Niakwa Place, Winnipeg 6, Manitoba, Canada. B. J. Medical College (India) 1960. Board certified. Partnership, solo, or will organize department. Available May 1971.

CARDIOLOGY—Lawrence K. Harris, M.D., 70 Maplewood Drive, Maple Shade, New Jersey 08052. Dalhousie (Nova Scotia) 1965. Board eligible. Hospital or group. Available July 1971.

FAMILY PRACTICE—Nabil El-Deiry, M.D., 155 East Godfrey Ave, #0103, Philadelphia, Pennsylvania 19120. Ein Shams University (Cairo) 1959. Group, partnership, or solo. Available July 1971.

GENERAL PRACTICE—Suman K. Dass, M.D., 16-15 SW Roxbury Street, Seattle, Washington 98016. Calcutta Medical College (India) 1956. Also emergency room. Available (temporary in northern New Jersey)

INTERNAL MEDICINE—Eugene M. Kern, M.D., Box "O," Gorgas Hospital, Balboa Heights, Canal Zone. University of Pennsylvania 1965. Subspecialty, gastroenterology. Board eligible. Group. Available August 1971.

Julius M. Jaffe M.D., 964 Del Canado, San Rafael, California 94903. Leiden University 1963. Subspecialties, hematology and oncology. Board eligible. Association, hospital staff, or group (southern New Jersey). Available July 1971.

NEUROLOGY—Michael Weintraub, M.D., 31 Risley Road, Chestnut Hill, Massachusetts 02167. SUNY (Buffalo) 1966. Board eligible. Solo, partnership, or group. Available May 1971.

OBSTETRICS AND GYNECOLOGY—M. H. Rezaee, M.D., 2532 Queenston Road, Cleveland Heights, Ohio 44118. Pahlavi (Iran) 1959. Board eligible. Solo, partnership, or group. Available.

Myung H. Han, 1130 Stadium Avenue, Bronx, New York 10465. Woo-Suk University (Korea) 1962. Subspecialty, gynecologic endocrinology. Board eligible. Full time in a hospital, group, or partnership. Available July 1971.

OPHTHALMOLOGY—Elia S. Toueg, M.D., 239 East 79th Street, New York 10021. Cairo University, UAR, 1950. Board eligible. Salaried, group, or partnership. Available December 1970.

F. K. Michail, M.D., 676 Park Avenue, East Orange, New Jersey 07017. Cairo University, UAR, 1960. Board eligible. Partnership. Available December 1970.

Donald A. Feretti, M.D., 1865 Old York Road, Abington, Pennsylvania 19001. Hahnemann 1964. Board eligible. Group or partnership. Available July 1971.

Herman C. Jordan, M.D., 2 George Road, Winchester, Massachusetts 01890. Howard University 1964. Board eligible. Solo, associate, or group. Available July 1971.

ORTHOPEDICS—Charles F. Mess, M.D., 3821 Third Street, NW, Rochester, Minnesota 55901. New Jersey College of Medicine 1964. Group. Available July 1971.

OTOLARYNGOLOGY—Bardev Kapila, M.D., 142-20 84th Drive, Jamaica, New York 11435. Amristar Medical College (India) 1960. Board certified. Group, partnership, or solo. Available.

Melvin J. Gunsberg, M.D., Box 3 DeWitt Army Hospital, Fort Belvoir, Virginia 22060. NYU 1963. Board certified. Group, partnership, or solo. Available August 1971.

John B. Sekel, M.D., 4823 Flanders Avenue, Kensington, Maryland 20795. Georgetown 1966. Board eligible. Group, partnership, or solo. Available July 1971.

Alvin D. Oscar, 3319 Royal Oak Court, Columbus, Georgia 31907. Jefferson 1964. Board eligible. Partnership or associate. Available October 1971.

PATHOLOGY—A. Ronquillo, M.D., 310 Washington Street, Newark, New York 14513. University of Santo Tomas 1961. Board eligible. Partnership or hospital. Available.

William D. Kelly, M.D., 801 Larchmont Road, Elmira, New York 14905. Georgetown 1947. Board certified. Available May-July 1971.

PEDIATRICS—M. R. S. Parand, M.D., 11 Stephen Hopkins Court, Providence, Rhode Island 02404. Pahlavi (Iran) University 1959. Group, partnership, or solo. Available.

Leon F. Kukla, M.D., 4730 North Post Road, Indianapolis, Indiana 46226. New Jersey College of Medicine 1966. Board eligible. Group, partnership, or institution. Available August 1971.

Richard G. Judelsohn, M.D., 2026A Tycoon Road, Atlanta, Georgia 30341. SUNY 1967. Board eligible. Associate or group. Available July 1972. (Buffalo)

RADIOLOGY—Gamal-Eddin H. Hussein, M.D., 2411 Fifth Street, Fort Lee, New Jersey 07024. Ain-Shams University of Medicine 1957. Board eligible. Any position. Available.

SURGERY—Rodigo Vilar Blanco, M.D., Doctors' Hospital, East End Avenue, New York 10028. Santiago (Spain) 1953. Board eligible. Group or partnership. Available.

Rolf H. Bessin, M.D., 6136 East Pratt Street, Baltimore, Maryland 21224. George Washington 1964. Board eligible. Group or partnership. Available August 1971.

Alan I. Josephson, M.D., 23 Parkside Drive, Hanover, New Jersey 07936. Tufts 1962. Board certified. Group or Partnership. Available.

Gan L. Maddinar, M.D., 41-30 43rd Street, Sunnyside, New York 11104. Nagpur College (India) 1962. Board certified. Group, partnership, or academic. Available February 1971.

Candido Deborja, M.D., 280 River Road, Apt. 4-B, Piscataway, New Jersey 08854. University of Santo Tomas 1961. Board certified. Group or partnership. Available.

Choon Myong Park, 8700 Pennsburg Place, #4, Richmond, Virginia 23229. Seoul National University 1960. Board eligible. Group or partnership. Available July 1971.

UROLOGY—T. Jagannathan, M.D., 1 Liberty Street Apt. F6, Little Ferry, New Jersey 07643. University of Madras (India) 1961. Board certified. Group or partnership. Available.

Richard W. Kecsai, M.D., 4905 East Harry Street, Apt. 115, Wichita, Kansas 67218. Jefferson 1964. Board eligible. Group, solo, associate, partnership, or government. Available August 1971.

Surgeons At A Meeting

Many of us are bored at meetings, but with the advancing front of red-tape, we will be going to more and more meetings. Surgeons are especially hard-hit by ennui, since, by temperament, surgeons like to do things. Accordingly, George E. Moore, M.D., of the editorial council of the *New York State Journal of Medicine* has published in the February 17, 1970 issue, the following survival kit for impatient MD's at meetings:

The need is evident to anyone who has been asked to participate in hospital review boards, bed utilization committees, or a medical alumni advisory group, and the fashionable regional, comprehensive, urban, community, and human relations boards. The increasing number of such meetings requires development of technics to insure survival without risking brain damage from several hours of boredom and adverse physiologic effects of everything stasis.

Doodling is socially acceptable but, unless one

is prepared, it is a limited exercise. The experienced committeeman has taken a few art lessons and spends his time sketching portraits or caricatures of his fellow captives. This is a powerful weapon and can be used to devastate the meeting or a particularly annoying chairman.

Carrying on personal conversations is frowned on, and leaving the meeting at intervals with a colleague may be misinterpreted as reflection of physiologic aging which may be undesirable if one is ambitious to assume leadership.

Of course, one can always instruct one's secretary to call about fifteen minutes after the meeting is started, but this ploy can't be used too frequently or the intent becomes obvious.

One can volunteer to pour the inevitable coffee but unless this is done skillfully it may reflect on one's public image as a surgeon. Surreptitious exercise by tensing various muscle groups is excellent if it is done without involuntary grimaces. Naturally, it is best or wisest to avoid physical contact with adjacent committee members. It can be embarrassing to use a table leg for counter pressure only to find that (1) you have made a mistake of identification, or (2) the furniture is fragile and promptly ruptures.

Sleeping at a meeting is socially unacceptable. Physicians can be quickly identified since they fall asleep immediately after the lights are lowered to show slides. Shading one's eyes or even supporting the chin is suspect. The experienced participant is careful to maintain an uncomfortable position. The talented man nods, orients his head to the speaker, and smiles and votes while sleeping. Some internists have developed this facility as a result of prolonged daily "grand" rounds.

Last, always leave the meeting with a show of enthusiasm. Never fail to pick up the materials distributed during the meeting. Compliment your neighbors and the chairman, and depart rapidly as befits a busy man.

ANNOUNCEMENTS

Symposium on Cardiovascular Diseases

On Wednesday, April 21, at the Holiday Inn in Bridgewater, the Somerset County Heart Association will present an all-day symposium on cardiovascular diseases. The program includes three presentations in the morning, luncheon, a panel discussion and reception. There is no fee for any of the events, and your wife is invited to join you at luncheon and for the reception. An all-day program has been planned for her also. For reservations, write to Sanford S. Klein, M.D., Somerset County Heart Association, P.O. Box 852, Somerville 08876.

Clinical Application of Basic Sciences

The following programs, in its "Basic Sciences and Clinical Application" series, have been scheduled by the Burlington County Memorial Hospital for May:

May 6 Acute Problems of Drug Addiction

May 13 Acute Drug Intoxication

May 20 Amniocentesis in Pregnancy

May 27 Management of Breast Cancer

The American Academy of General Practice allows one and a half credits for attendance at each session. All meetings convene at 3:30 in the T. J. Summey Building of the Hospital. For further information, please contact the Director of Medical Education, Burlington County Memorial Hospital, Mount Holly.

Clinical Electroencephalography

A course in clinical electroencephalography will be held September 13 to 15, 1971, in Minneapolis. The course will review the principal applications of the EEG to clinical practice. It is sponsored by the American Electroencephalographic Society. For details, write to Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, Minnesota.

LETTER TO THE JOURNAL

Associates Are Here

February 22, 1971

Dear Sir:

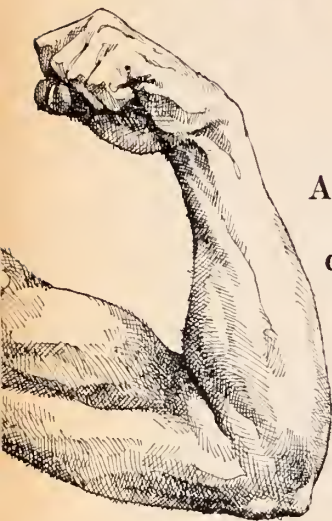
The comments on physicians' assistants and associates in Dr. Henry A. Brodtkin's January article and in the February editorial in *The Journal* missed several important points about these para-professionals. The basic assumption is that these individuals are and will be responsible to physicians and that physicians are and will be responsible for their activities. They are not a substitute for the physician, but personnel who can assist the physician, making it possible for the physician

to take care of more people and to take care of each individual more effectively. For generations, but increasingly over the last half century, physicians have relied on other professionals, such as nurses and laboratory personnel; physician's assistants and associates can assist them in gathering and interpreting data.

Physicians' assistants and associates are here. Programs for training them exist across the country. If New Jersey physicians do not utilize their skills, competitively they will slip behind the physicians of the many states where these people are established. If we physicians do not show initiative in the organization of medical care, including the use of properly trained personnel, we will soon find someone else organizing medical care for us.

(signed) Willard Dalrymple, M.D.

IF MORE MEN CRIED



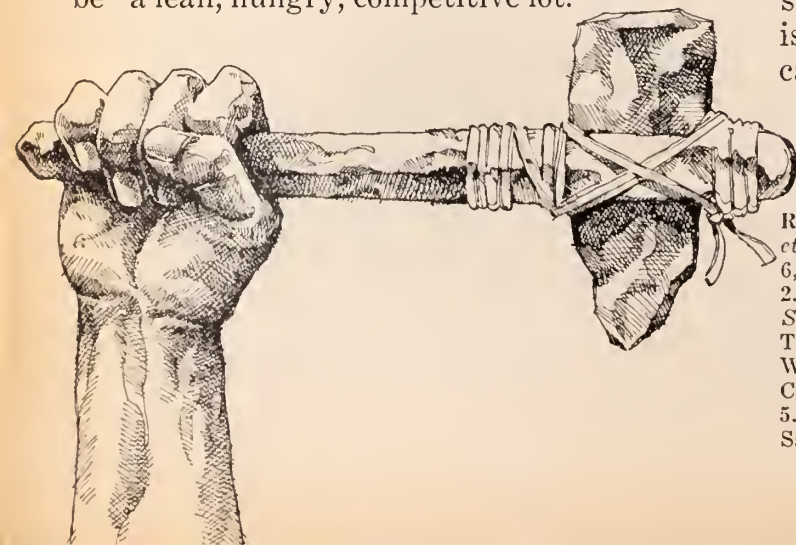
At least seventy-five out of one hundred adults with duodenal ulcers are men.¹

Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."²

Hypersecretion—an atavistic response.

Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."²

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."³



Big boys don't cry. If more men cried maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of



their genes and what they are taught. Schottstaedt observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.⁴ Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age

Take away stress you can take away symptoms.

There is no question that stress plays a role in the etiology of duodenal ulcers. Alvarez⁵ observes that many a man with a duodenal ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have a duodenal ulcer is the type least likely to take long vacations or take it easy at work.

The rest cure vs. the two-way action of Librax.[®] For most patients, the rest cure is as unrealistic as it is desirable. Still, the stress factor must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that cor-

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. J., et al. (eds.): *Harrison's Principles of Internal Medicine*, 6, New York, McGraw-Hill Book Company, 1970, p. 14. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff's Stress and Disease*, ed. 2, Springfield, Ill., Charles C. Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 1. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.

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...chlordiazepoxide
...Cl) with the potent
...nticholinergic
...tion of Quarzan®
...lidinium Br).

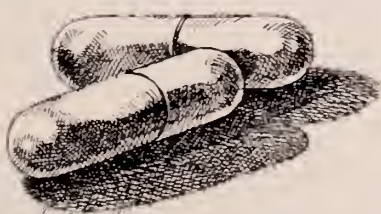


Protects man from his own hungry personality. The action of Librium reduces anxiety—helps protect the vulnerable patient from the psychological overreaction to stress that clutches his stomach. At the same time, the action of Quarzan helps quiet the hyperactive gut, decreasing hypermotility and hypersecretion.

An inner healing environment with 1 or 2 capsules, 3 or 4 times daily. Of course, there's more to the treatment of duodenal ulcer than a prescription for Librax. The patient—with your guidance—will have to adjust to a different pattern of living if treatment is to succeed. During this adjustment period, 1 or 2 capsules of Librax 3 or 4 times daily can help establish a desirable environment for healing.

Librax: It can't change man's nature. But it can usually make it easier for men to cope with the discomfort of stress—both psychic and gastric—that can precipitate and exacerbate duodenal ulcer.

Librax: Rx #60 1 cap. *a.c.* and 2 *h.s.*



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, over-sedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

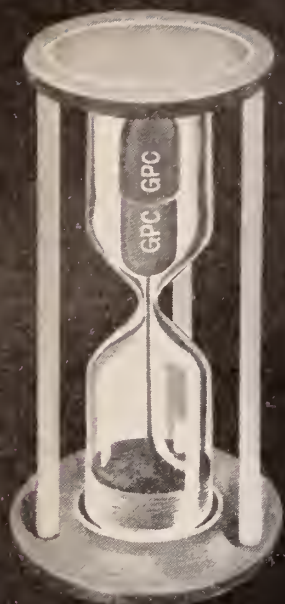
Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

- | | | |
|---------------|-----------|--|
| April | 17 | Academy of Medicine of New Jersey and NJCMDN
Martland Hospital, Newark
Workshop on Ketamine (Ketalar®) Anesthesia |
| 7 | | Academy of Medicine of New Jersey
Saint Barnabas Medical Center
Livingston
Symposium on Ecology |
| 7 | 20 | Warren County Medical Society |
| 7 | 20 | Academy of Medicine of New Jersey
Englewood Hospital, Englewood
Leukemia and Lymphoma |
| 7 | 20 | Academy of Medicine of New Jersey
Yale—New Haven Medical Center
New Haven, Connecticut
Endocrinology |
| and | | |
| 14 | | Holy Name Hospital, Teaneck
Uremia |
| 7, 14, | 21 | Somerset County Heart Association
Holiday Inn, Bridgewater
Cardiovascular Diseases Symposium |
| 21, 28 | | Columbus Hospital
Hospital Annex, Newark
Simplified ECG for the Family Physician |
| 8 | 21 | Academy of Medicine of New Jersey
Saint Michael's Medical Center, Newark
Cardiovascular Workshop |
| 8 | 22 | Burlington County Memorial Hospital
Mount Holly
Recent Advances in Diabetes Mellitus |
| 8 | | Sandoz Medical Lectures
Sandoz Auditorium, Hanover
The Disturbed Child |
| 8 | | Saint Barnabas Medical Center
Livingston
Irradiation Therapy |
| 13 | 22 | Burlington County Memorial Hospital
Mount Holly
Hypercalcemia |
| 13 | | Cumberland County Medical Society |
| 13 | 22 | Academy of Medicine of New Jersey and Radiological Society of New Jersey
Orange Memorial Hospital, Orange
Section Meeting |
| 13 | | Bergen County Medical Society |
| 13 | 24 | Academy of Medicine of New Jersey and New Jersey Society of Plastic and Reconstructive Surgeons
Princeton Hospital, Princeton
The Burned Face |
| 14 | | Middlesex County Medical Society |
| 14 | 28 | Englewood Hospital
School of Nursing Auditorium
Leukemia as Human Tumor Model |
| 14 | | TB-Respiratory Disease Association of Southern New Jersey |
| 14 | 28 | Academy of Medicine of New Jersey
St. Barnabas Medical Center
Livingston
Pre and Post Operative Care |
| 14 | | Academy of Medicine of New Jersey
Runnells Hospital, Berkeley Heights
Difficult Diabetic Patient |
| 15 | | Gloucester County Medical Society |
| 15 | | Morris County Medical Society |
| 15 | | Burlington County Memorial Hospital
Mount Holly
Management of Exogenous Obesity |
| 15 | | Academy of Medicine of New Jersey
Woodbury County Club, Woodbury
Hypertension |

- 29 Burlington County Memorial Hospital
Mount Holly
Interservice Seminar
- May
- 4 Academy of Medicine of New Jersey
Morristown Memorial Hospital
Morristown
Diagnosis and Treatment of Shock
- 4 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Drug Addiction
- 5 Camden County Medical Society
Tavistock Country Club
Haddonfield
- 5, 12, Columbus Hospital
19 Hospital Annex, Newark
Simplified ECG for the Family Physician
- 6 Saint Barnabas Medical Center
Livingston
Familia Toxemia
- 6 Burlington County Memorial Hospital
Mount Holly
Drug Abuse
- 11 Academy of Medicine of New Jersey
Overlook Hospital, Summit
Diagnosis and Treatment of Shock
- 13 Burlington County Memorial Hospital
Mount Holly
Management of Acute Drug Intoxication
- 15 The Medical Society of New Jersey
to Haddon Hall, Atlantic City
18 Annual Meeting
- 20 Burlington County Memorial Hospital
Mount Holly
Amniocentesis and Amnioinfusion in Preg-
nancy
- 26 Academy of Medicine of New Jersey
Mayfair Farms, West Orange
Annual Awards Dinner
- 27 Burlington County Memorial Hospital
Mount Holly
Breast Cancer
- 27 Academy of Medicine of New Jersey
and Radiological Society of New Jersey
Orange Memorial Hospital, Orange
Section Meeting
- June
- 3-4 Saint Barnabas Medical Center
Department of Obstetrics and Gyne-
cology, Livingston
Gynecologic Endoscopy
- 24 Academy of Medicine of New Jersey
and Radiological Society of New Jersey
Orange Memorial Hospital, Orange
Section Meeting
- October
- 25-29 Saint Barnabas Medical Center
Department of Obstetrics and Gyne-
cology, Livingston
Obstetric and Gynecologic Pathology
- November
- 10 New Jersey Dental Association
Semi-Annual Session

OBITUARIES

Dr. Thaddeus L. Deren

On February 6, 1971, at the untimely age of 45, Thaddeus L. Deren, M.D., died after a brief illness. Dr. Deren was a urologist, an associate at Hahnemann Hospital and chief of urology at St. Luke's Children's Hospital in Philadelphia. He directed the urologic ser-

vice at the Rancocas Valley Hospital in Willingboro. A 1954 graduate of Hahnemann, he practiced in Philadelphia until 1961, when he moved to our state and became a member of the Burlington County Medical Society.

Dr. F. Chester Forte

Born in Boston in 1903, F. Chester Forte, M.D., died at his home in Saddle River on February 14, 1971. He earned his M.D. at Tufts in 1930. Following internship, he

moved to Hackensack and served the people of Bergen County for 40 years. He was a general practitioner on the Hackensack Hospital staff, and for three decades he was attending physician at the Conklin Home for Children.

Dr. Eugene A. Hauber

Eugene A. Hauber, M.D., won his baccalaureate degree at Notre Dame in 1927 and his M.D. at St. Louis University in 1931. He interned at St. Francis Hospital in Jersey City and then moved to Sayreville. Dr. Hauber was a family doctor in Middlesex County, on the staff of St. Peter's Hospital in New Brunswick, and for more than 30 years the school physician in Sayreville. Dr. Hauber died on February 12, 1971 at the age of 69.

Dr. William A. McMurtrie

At the grand age of 91, William A. McMurtrie, M.D., died at his home in Morristown on February 8, 1971. He was born in 1880 (when Rutherford B. Hayes was President of the United States) and received his M.D. from Cornell in 1905. He practiced in Morris County from 1907 until he retired in 1964. He served both Morristown hospitals, and during World War I was a captain in the medical corps of the Army of the United States. He was a laureate of our Golden Merit Award in 1957.

Dr. Bertram H. Smith

On February 2, 1971, Bertram H. Smith, M.D., died at the age of 65. A 1931 alumnus of the Hahnemann Medical College, he was a family doctor with a special interest and skill in otology and laryngology. Dr. Smith was in the Army Air Corps as a medical officer from 1942 to 1946. He was affiliated with the Camden County General Hospital at Lakeland and the West Jersey Hospital in Camden.

Dr. Arthur A. Scullion

Born in 1899, Arthur A. Scullion was 72 years old at the time of his death on January 25,

1971. He earned his baccalaureate degree at Dartmouth and his M.D., conferred in 1926, was from the University of Maryland. Dr. Scullion was active in civic affairs in Bergen County and was president of the United National Bank in Cliffside Park. He was, for more than a decade, senior school physician in that community. He was on the staff of both St. Vincent's Hospital in Montclair and the Holy Name Hospital in Teaneck. Dr. Scullion was a surgeon and a Fellow of the American College of Surgeons.

Dr. William F. Wacker

Born in 1901, William F. Wacker, M.D., died on February 8, 1971, at the age of 70. He was a general practitioner with special interest and skill in laryngology and otology. For several decades he practiced in Hillside (where he was school physician) and in 1967 he moved to Lakewood and devoted himself to rheumatology and geriatrics. He was, during the 1940s, active in committee work with our Union County Medical Society. Dr. Wacker was a 1931 graduate of the College of Physicians and Surgeons of Columbia University.

Dr. Louis S. Wegryn

One of our Past-Presidents, Louis S. Wegryn, M.D., died at the age of 68 on February 14, 1971. (Editorial comment on Dr. Wegryn's passing will be found on page 183 of the March 1971 issue of *The Journal*.) Dr. Wegryn, who received his M.D. from the University of Illinois in 1927, was a native of Elizabeth and prominent in civic affairs in that city. He was a surgeon affiliated with all three hospitals there and had served as chief of staff at the Alexian Brothers Hospital. He was President of the Union County Medical Society, and in 1962 became President of The Medical Society of New Jersey. He was a Fellow of the American College of Surgeons and was active in the work of the International Academy of Proctology. He was on the editorial board of the *American Journal of Proctology*.

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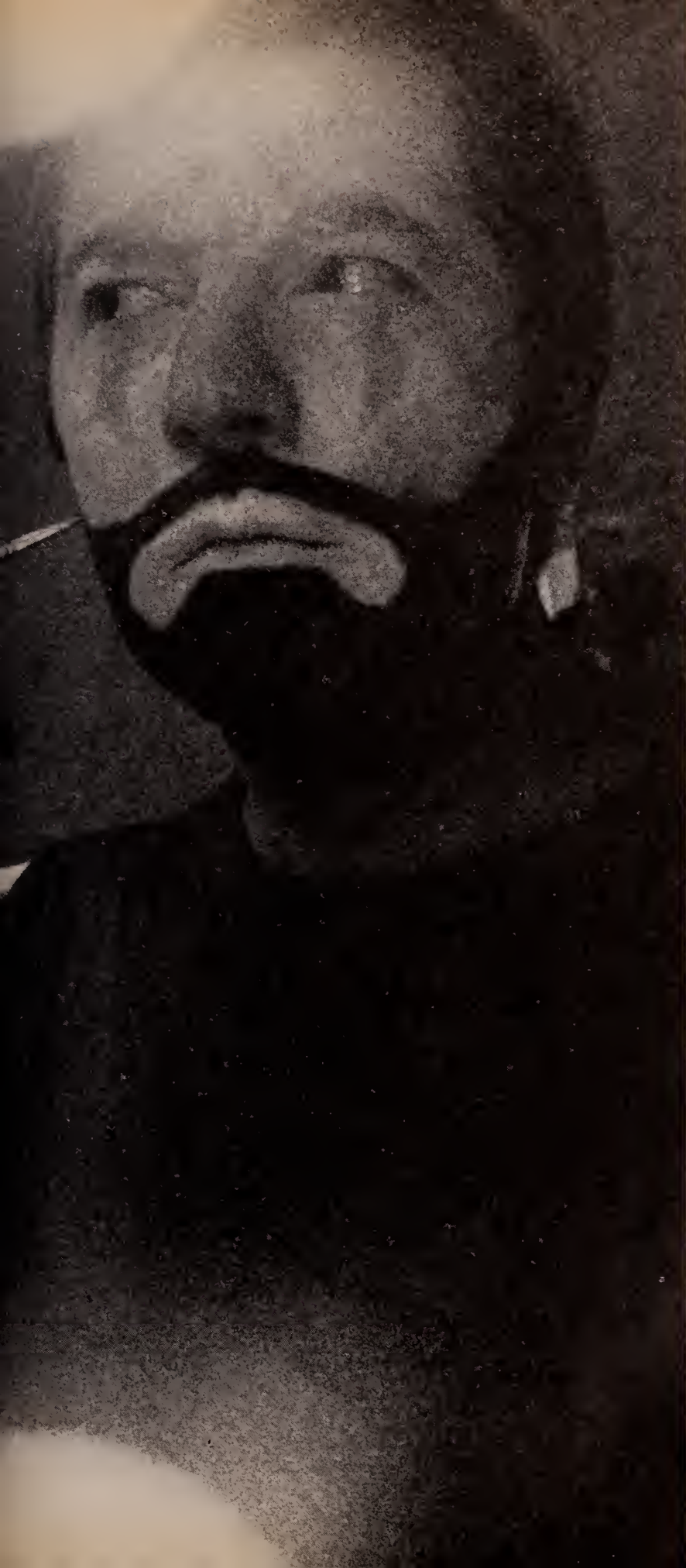
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Pro-Banthine 15 mg.
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Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

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Contraindications: Glaucoma, severe cardiac disease.

Warnings: Pro-Banthine with Dartal should not be administered to patients who are under the influence of barbiturates, alcohol or narcotics. The drug should be administered cautiously to epileptic patients or those in depressed states, patients with liver disease and to pregnant women. Hypersensitivity to Dartal may occur rarely in patients with known sensitivity to similar drugs.

Side Effects: Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

Adult Dosage: One tablet three times a day.

Pro-Banthine® 15 mg.
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with

Phenobarbital 15 mg.

Warning: May be habit-forming.

For **Indications**, **Contraindications**, **Precautions**, **Side Effects** and **Dosage** see Pro-Banthine. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

Pro-Banthine P.A.®

prolonged acting brand of propantheline bromide
For **Indications**, **Contraindications**, **Precautions** and **Side Effects** see Pro-Banthine.

Dosage Form: Capsule-shaped, compression-coated, peach tablets of 30 mg. for oral use.

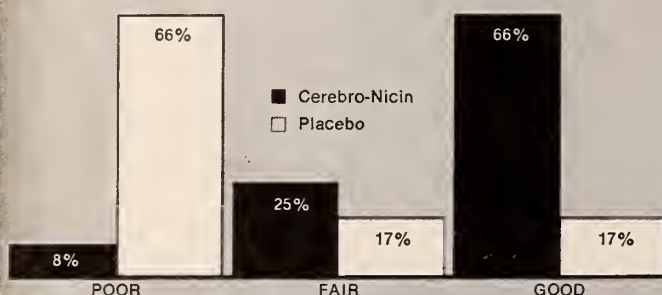
Dosage: The recommended initial dosage is one tablet in the morning and one at night.

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CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

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Pentylentetrazole.....	100 mg.
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Pyridoxine.....	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8oz. bottles.

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Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.



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Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

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100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

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Each orange tablet contains:

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Thiamine HCl 10 mg.

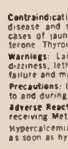
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Pyridoxine HCl 5 mg.
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Dose: 2 tablets daily.
Available: Bottles of 60, 500



Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcaemia, coronary heart disease and hypertension. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting, abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema. Hypercalcaemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcaemia is detected.

References: 1. Montano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dubin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tillet, E. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:5, 1967. 4. Newman, L., Bradley, K. L., Zimet, B., Fekuhama, O. K., and Salinger, T. F. Thyroid androgen interactions and the psychosomatic effect of androstenedione. J Clin Endocr 19:836, 1959. 5. Farrel, E. J., and Keller, S. W. Effects of L-thyroxine and l-thyronine on spermatogenesis. J Urol 79:853, 1958. 6. Oski, J., and Farrel, E. J. United States Dispensary, ed 251. Lippincott, Philadelphia, 1955. p. 1432. 7. Wersbach, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959. pp 79-99.

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BOOK REVIEWS

The Face in Genetic Disorders. R. M. Goodman, M.D. and R. J. Gorlin, D.D. St. Louis, 1970, Mosby. Pp. 169. 276 illustrations. (\$19)

At the turn of the century medical students were taught to take meticulous family histories, and to look into the family background for various "hereditary taints"—as the phrase then was. By the 1930s, however, the emphasis had shifted. The role of heredity became underplayed, with thesis that the body and mind were plastic materials to be moulded by environment and the culture. Today, however, there has been a renaissance of interest in genetics. The present work, recognizing that genetic disorders often involve multiple systems, concentrates on facial features as diagnostic aids. The disorders are presented alphabetically from achondroplasia to xeroderma. For each syndrome there are illustrations, tabulations, and narrations. There is usually a line or two about treatment—mostly such items as endocrine administration, cosmetic surgery, neurosurgery, or even "symptomatic treatment."

The book includes a good chapter on genetic counseling with some discussion of the mathematics of the risk factor. ("Most patients," say the authors, "consider risks of less than 10 per cent compatible with further reproduction.")

As is always the case with writing about genetic disorders, the reader is confused by the proliferation of eponyms—Goldenhar's syndrome, Steinert's Disease, Rubinstein-Taybi syndrome, and the like. However, this text does provide a road-map through that eponymic jungle, and the good illustrations convert this book into a unique modern atlas of the subject.

Victor Huberman, M.D.

The Frozen Cell [Ciba Foundation]. Edited by G. E. W. Wolstenholme and Maeve O'Connor. Baltimore, Maryland, 1970, Williams and Wilkins. Pp. 316. Illustrated. (Price not stated)

This newest volume in the Ciba Symposium series continues the tradition of excellence and high scholarship, well established by previous books. Participants in this conference were from the United States, England, France, West Germany, Holland, and Japan. All have a keen interest in cryobiology and approach the subject from specialties ranging from basic chemistry to clinical blood banking. The first presentation is concerned with the stoichiometry and chemistry of the polyhedral hydrates. This is a good review of a difficult subject. The penultimate chapter deals with electron microscopic and functional changes in smooth muscle associated with freezing and thawing. The twelve chapters in between cover the physical and biologic changes produced in many different cells and tissues by freezing and thawing. The final discussion explores the entire problem of osmotic shock as the chief cause of damage in frozen and thawed cells. Not all the questions are answered but some have been partially clarified. This is an

excellent book and is recommended reading for anyone with an interest in cryobiology regardless of his specialty.

Hugh F. Luddecke, M.D.

Immunology of Malignant Disease. Jules E. Harris, M.D. and Joseph G. Sinkovics, M.D. St. Louis, 1970, Mosby. Pp. 251. (\$15)

Although this text is intended for clinicians managing patients with malignant disease, it also offers a background of information about immunology in relation to malignant disease which will be appreciated by all physicians treating patients. The text is well organized and easily read. The authors discuss human immune response as well as experimental studies.

Any physician involved in the chemotherapy of malignant disease today will appreciate the mass of information in Chapters 3 and 4 on human deficiency states and human immune responses. I found Chapter 5, on tumors of man, of great interest. The book contains an extensive bibliography following each chapter, and this will be a great assistance in the understanding of the life processes and their disturbances in this particular group of patients.

Albert Abraham, M.D.

Training and Conditioning of Athletes. Max M. Novich, M.D. and Buddy Taylor, M.S. Philadelphia, 1970, Lea and Febiger. Pp. 274. Illustrated. (\$6)

With emphasis on their beginning quotation from Montaigne's essay on *Education of Boys*, which states, "... the body and mind should be fashioned at the same time ... they must not be separated," the authors offer a comprehensive review of the many medical aspects of sports. They believe that sports contribute substantially to the objects of education. Prior to World War II, coach and trainer were largely in command of the athlete's medical problems, with very inadequate physician communication. Today, the team physician is in charge of all medical problems and with the assistance of the trainer, a good job is being done. However, with increased recognition of the importance of the preseason physical examination, which is noted, I suggest the need for two physicians, one medically oriented and one for the many orthopedic problems encountered.

The chapter on prevention and treatment of athletic injuries includes everything from the all important knee to the less common "javelin elbow" which is to be distinguished from "tennis elbow." Other chapters amply cover equipment, physical therapy, conditioning, drugs, field examinations, and electrolyte balance.

While electrolyte and fluid balance in heat stress is discussed, the newer more practical method of prophylactic field replacement with properly balanced electrolyte solutions (including potassium) as an aid to sport, rather than the more haphazard use of irritating salt tablets and water could have been brought in.

Dr. Novich has a wealth of background and information as an athlete (he still likes boxing), coach, orthopedic surgeon, and team physician for Olympians, Maccabiah teams and the Jersey Jay football team. Mr. Taylor, who is now with the Utah Stars Basketball Club, adds his broad knowledge as trainer of many years. The book is a good addition to the library of all those involved in the medical aspects of sports.

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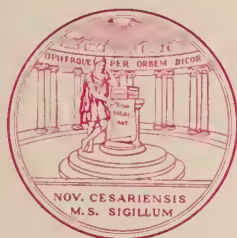
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MAY, 1971
VOL. 68, NO. 5

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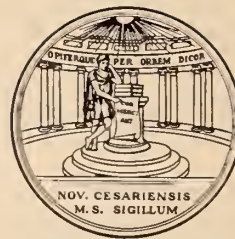
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David B. Allman* 1891-1971

In any organization a member must possess the traditional leadership qualities, if he is going to reach the top. In medical societies there is an added qualification. He must be a good physician, too. If he cannot earn the professional respect of his brethren, his leadership skills (and even the best public relations expert) won't help him. Our state has had only one doctor to reach the top of the AMA pyramid: David Bacharach Allman.

Dr. Allman's leadership qualities are too well-known, too deeply imprinted in the archives of American medicine to need the bouquet of any additional details here. But, because of his own lack of pretentiousness and unwillingness to boast, his medical and surgical skills have not been as emphasized in the medical community at large as they are known to Atlantic County doctors. He was actually one of the founders of the American Board of Surgery. In a tribute to "David Allman, The Physician," Maurice Bear Gordon, M.D., (in the July 1957 issue of this *Journal*) once put it this way, "when he operated every case looked simple." The annals of the Atlantic City Hospital are replete with anecdotes and examples of Dr. Allman's surgical wizardry.

With new interest in genetics, more of us are coming to believe that familial factors do play a role in shaping a man's life portrait. When our David was a boy he lived in the home of his maternal grandparents, Jacob and Betty Bacharach. Betty Bacharach (for whom the unique Betty Bacharach Home was named) was our man's grandmother. One of the sons of Jacob and Betty Bacharach was, for two decades, a member of the Congress of the United States. Another son was, for years, mayor of Atlantic City.

Dave Allman, without trying, collected awards

and accolades the way some people collect stamps. His county medical society issued a gold citation. The State of New Jersey called him our State's outstanding citizen. The U.S. Navy cited him in World War I and the Public Health Service in World War II. (So did the Coast Guard.) He usually put the awards and citations quietly away. If he hadn't they would have overflowed the office.

To our own Society, he gave long, generous, and untiring service. For years he was chairman of our indispensable Finance and Budget Committee. He was a Trustee for two decades, including one biennium as chairman of the Board. He was a member of, and for a time, President of the New Jersey State Board of Medical Examiners. It seemed impossible for him to slip into an organization and just sit on the sidelines. Sooner or later they would be asking him to accept an office.

All kinds of flowery phrases can be uttered to condole his death and praise his life. He would have preferred the simple ones: a charismatic leader, a splendid organizer, a good neighbor, and above all a superb physician and surgeon. Forget the long list of honors. Dave Allman would have agreed that these few phrases are enough for any man.

Emergency Is What The Patient Thinks

A quarter of a century ago, the hospital's emergency room was a place for accidents and emergencies. "Now," writes our own Spencer Snedecor, "... it is a new method of medical care for the people of this country, a general practice headquarters for communities at night. The emergency is what the patient feels."**

* A formal obituary of Dr. Allman will be found on page 458 of this issue.

**In the January 1971 issue of *Medical World News*

In a sense, the emergency *department* (in most places it isn't an emergency *room*) is the point of entry into the American health system for a high proportion of patients. Various surveys cite figures like 15 or 20 or 25 per cent for the number of genuine traumatic accidents, indicating that most of the visits are not really "accident cases" at all. Usually, the critics of the process argue that most of the cases could have been handled just as well in the office of a general practitioner. Surveyors of the ER scene estimate that 10 per cent (or in some more broadly defined studies 15 or 20 per cent) of the patients are "really sick." But, as Dr. Snedecor suggests, the genuineness of the emergency is what the patient, not the doctor, thinks it is. There is an inverse relationship between the flow of patients in an ER and the concentration of M.D.s in the neighborhood around the hospital. In most places, emergency departments run at a financial loss which has to be borne by the hospital. Even where ER fees are comparable with fees charged by private practitioners, there are enough uncollectible services to put the whole operation in the red.

All kinds of theories have been advanced for this rising tide of admissions to the emergency department.[†] Thus, it has been said that the high mobility of the American people is a factor, since many people don't stay long enough in one community to have a real family physician. Or, the reluctance of doctors to make house calls has been indicated. Some physicians tell patients to meet them in the emergency room of the hospital, since there, at one place, will be facilities for x-rays, putting on casts, and so on. Indeed, this matter of having ready supplies and equipment has, in some places, resulted in the rich and sophisticated coming into emergency rooms. A recent survey in Michigan[†] indicated that more than half the patients who visited emergency rooms had made no effort to locate a private practitioner first. Emergency departments see more non-traumatic cases than they do accidental injuries.

[†]Medical World News published a two-part series entitled "Crisis in Emergency Care" in its last 1970 and first 1971 issues.

Efforts have been made to upgrade standards of emergency room practice. In this *Journal* (August 1970, page 480) Robert Wegryn, M.D., presented a thoughtful analysis of the problem and suggested standards. Hospitals worry, too, about legal and insurance problems that develop. In over-populated areas of a city the emergency rooms tend to be crowded with patients and applicants for care, with the result that triage and the setting of priorities may become a real problem. Some hospitals permit nurses, or even clerks, to make the preliminary sorting out of patients to determine which ones need the swiftest attention.

In spite of all the difficulties (primarily understaffing and underfunding) we do have a responsibility to keep that ever-lighted door to which people may turn in emergencies even if, in fact, most of the visits there are not for emergencies.

Robert R. Cadmus, M.D.

It would not be fitting to let pass the departure of Dr. Cadmus without a word about his contribution to medical education—and in a broader sense, medical citizenship in our state. He presided over the transition of a medical school from a private to a state-operated institution. He was the moving spirit behind the construction of the new campus. He established numerous teaching affiliations. He was able to secure federal funding for many educational projects in New Jersey medicine.

Perhaps even more significant was his sensitivity to problems of our citizens. He always saw the practice of medicine as a social science as well as a biological one. He could never tolerate the concept of a medical school as something isolated from, even aloof from, the community around it. He had a finely honed sense of the citizenship duties of the profession and its professors. He has established a superb model for his successors in the medical school presidency.

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The transformation of one type of malignant tumor to another must be an exceedingly rare phenomenon. Here, however, are two examples.

Chronic Lymphatic Leukemia And Lymphosarcoma

Terminating In Multiple Myeloma

**Marvin Shuster, M.D.,
Wilfredo C. Causing, M.D., et al.*
Perth Amboy**

This report describes two patients with malignant disease of the lymphocytic system transforming and terminating as multiple myeloma. One patient first presented with chronic lymphocytic leukemia and the other had lymphosarcoma.

While it is known that myeloma cells are neoplastic, the origins of the plasma cell and its relationship to other cells have been subject to dispute. An extensive search of the literature showed no report of such cases of transformation from malignant lymphocytic disease to myeloma. Strobbee recorded the simultaneous presence of chronic lymphocytic leukemia and multiple myeloma but made no mention of metamorphosis of the type described herein.

Case One

A 54-year-old male was first admitted in December 1964, with pressure symptoms from massive hepatosplenomegaly. At that time, his white blood cell (WBC) count was 68,500 with 86 per cent lymphocytes; bone marrow aspiration was diagnostic of chronic lymphocytic leukemia. Treated with Chlorambucil* and steroids he did well in general, but the splenomegaly did not completely regress.

In May 1967, he was admitted to Perth Amboy General Hospital with a perforated duodenal ulcer treated with plication. He did well and was discharged one week after surgery. During that admission, a protein electrophoresis revealed a decrease in albumin with an increase in alpha 1 and alpha 2 globulins; however, no abnormal spike was seen.

In May 1968, he was admitted because of hematuria and ecchymoses. At that time, a circulating anticoagulant was noted and the partial thromboplastin time, prothrombin time, coagulation time, and Hicks-Pitney thromboplastin generation test were prolonged. The thromboplastin generation test was not corrected by substitution of known platelet factor, known factor IX, or known factor VII. He was treated with steroids and a short course of 6-mercaptopurine with no apparent improvement. From June, 1968 to June, 1969 he received no myelotoxic agents. He had occasional ecchymoses but no gross bleeding episodes. Follow-up prothrombin time tests remained approximately three-fold greater than control levels.

In April 1969, he developed a marked pancytopenia. Bone marrow at that time revealed hypercellularity, with 20 per cent erythroid cells showing a normoblastic maturation. The granulocytic series made up 40 per cent of the myeloid cells with some maturation arrest noted. There were 26 per cent lymphocytes. Additional focal aggregates of lymphocytes were observed in the bone marrow sections. Megakaryocytes were normal in number but many demonstrated minimal thrombocyte formation. The over-all impression was that of hypersplenism. Blood transfusion and steroid therapy produced some improvement in his blood count.

In May 1969, he developed low back pain which became more severe over the next month and he was hospitalized in June 1969. Admittance x-ray studies showed collapse of the first three lumbar vertebrae. He had severe backache, weakness, anorexia, and recurrent bleeding from hemorrhoids and occasional hemoptysis. He had a profound pancytopenia, splenomegaly, and high levels of circulating anticoagulants. The spleen was enlarged 4 fingers below the costal margin. Protein electrophoresis at this time revealed a monoclonal gammopathy with a prominent gamma spike.

In July 1969, bone marrow examination revealed 64 per cent distinctly abnormal plasma cells, 12 per cent lymphocytes, 13 per cent erythroid cells, and 11 per cent granulocytes. Most of the plasma cells were immature with one or two nucleoli. Protein electro-

* Co-authors are Alan Young, M.D., Arpad Gerard, M.D., Gonzalo Ramirez, M.D., and Remigio Dinio, M.D. This work is from the Department of Laboratories and the Department of Medicine, Perth Amboy General Hospital, Perth Amboy, New Jersey.

phoresis again showed a gamma spike representing 46 per cent of the total protein. Bone survey revealed multiple lytic areas involving the skull, right humerus, and both femurs. Urinary Bence-Jones protein was absent. Immunoelectrophoresis revealed an increase of IgG globulin. The patient developed septic fever with shock and died apparently of overwhelming infection. Necropsy revealed multiple myelomata involving skull, vertebrae, sternum, large bones, liver, spleen, lymph nodes, kidneys, and small intestine. Extensive bronchopneumonia was also found.

Case Two

A 58-year-old male was admitted to the Perth Amboy General Hospital on March 26, 1968, with tarry stools and general weakness of two weeks' duration. The tarry stools showed 4 plus occult blood. Normal studies included: SMA-12, urinalysis, VDRL, coagulation profile, Schilling test, sickle-cell test, ECG, liver scan, chest x-ray, gastroscopy, and barium enema. The upper gastrointestinal series was suggestive of a duodenal ulcer. Hemoglobin was 7 Gm. per 100 ml., hematocrit 25 per cent, WBC 4,200 with neutrophils 53 per cent, lymphocytes 36 per cent, monocytes 7 per cent, eosinophils 2 per cent, atypical mononuclears 7 per cent, and occasional target cells. Platelets were adequate.

On March 28, he received two units of packed RBC which raised the hemoglobin to 11. The stool returned to normal color, but the occult blood remained strongly positive until his discharge on April 12, when his hemoglobin was 8.9. Then, on May 20, he was admitted to the Newark Beth Israel Medical Center because of anemia, with hemoglobin of 7. Exploratory laparotomy revealed a well-circumscribed, walnut-sized tumor in the small intestine. A diagnosis of lymphosarcoma with metastasis to one regional lymph node was made. Bone biopsy showed similar involvement of the marrow. Chlorambucil® was given but was discontinued later because of low leukocyte count.

He was readmitted to the Perth Amboy General Hospital in September, 1968, because of progressive weakness and intermittent fever. Physical findings were essentially normal. He then had hemoglobin of 7.8, with macrocytosis, basophilic stippling, and rouleaux formation. Peripheral blood smears on several occasions revealed plasma cells from 30 to 60 per cent. Other studies included: IgA 560 mg., albumin 2.1, globulin 5.8, and an A/G ratio of 0.56. Reticulocytes were 4.3 per cent, and Coombs test was negative. Serum electrophoresis revealed a spike in the beta fraction. There was 2 plus proteinuria and a Bence-Jones protein was positive on two occasions, although a radioisotopic liver scan was normal.

Iliac bone marrow aspiration on September 20 revealed hypoplasia, and sternal bone marrow on the same day revealed erythroid hyperplasia with megaloblastoid maturation, with 10 per cent lymphocytoid-plasmacytes. In some areas, these appeared as nests of cells with eccentric nuclei and large nucleoli; a few of the atypical plasma cells contained Russell bodies. Atypical lymphocytes were also seen, some of which were binucleated. He was given two units of packed RBC. Polycillin®, Cytosan®, prednisone, and testosterone. In a few days the patient became afebrile and showed remarkable improvement. He was discharged on October 14, 1968, on Cytosan®, testosterone, and prednisone.

When readmitted on March 16, 1969, because of gen-

eral deterioration of his condition, his hemoglobin was found to be 7. He was transfused with four units of whole blood. Bone marrow aspiration on March 21, showed multiple myeloma. Urinary Bence-Jones protein test was positive, but bone survey failed to reveal any lesions. On May 12 the urine showed 3 plus protein and blood studies included BUN 38, uric acid 10, total bilirubin 1.5, total protein 8.4, and an A/G ratio of 0.44; LDH 275 units, alkaline phosphatase 26 Bodansky units, SGOT 47 K.U., hematocrit 23 per cent, hemoglobin 7.8, RBC 2.5 million, WBC 4500, with 9 per cent bands, 7 per cent neutrophils, 1 per cent lymphocytes, 2 per cent monocytes, 1 per cent eosinophils, 77 per cent atypical mononuclears, and 3 per cent myelocytes. Most of the atypical mononuclears were of the lympho-plasmacytoid type. There were 3 nucleated RBC's/100 WBC and rouleaux formation. He deteriorated rapidly and expired on May 16, 1969. Autopsy permission was not granted.

Discussion

The plasma cell was discovered and accurately described by Ramon y Cajal in 1890. He named it the cyanophil cell and believed that it originated from tissue lymphocytes. Marchalko considered that plasma cells came from hemic lymphocytes, reasoning that in foci of artificially produced inflammation the number of plasma cells was so great, and their appearance so sudden, as to exclude a possible origin from tissue elements; lymphocytes when grouped about the wall of a blood vessel were so arranged that plasma cells occupied the outermost regions of the infiltration, while lymphocytes were nearest to the vessels; in aseptic reparative processes plasma cells were never seen; and in leukocytosis experimentally produced with tubercle or bacterial proteins, plasma cells and transitional stages were plentiful within blood vessels.

Maximow and Bloom reported that plasma cells could develop from lymphocytes and that this transition could be followed in tissue culture. Early concepts of myeloma cell origin included lymphocytes, myeloblasts or erythroblasts as the immediate precursors. Michels, in a detailed 1931 review of the morphogenesis, functions, and development of the plasma cells pointed out that amitosis leading to the formation of multinucleated cells is a frequent phenomenon. He listed four hypotheses of plasma cell origin: (1) histogenous origin from the connective tissue cells, including tissue lymphocytes, hemohistioblasts, etc.;

(2) a hematogenic origin from emigrated lymphocytes; (3) mixed origins from emigrated lymphocytes (monocytes) or pre-existent tissue lymphocytes; and (4) an origin from immature blood cells (myeloblasts, hemoblasts, erythroblasts) through aberration or abortions.

Maximow's tissue culture (1922-1923) showed that in explants of lymphoid tissue, plasma cells developed from local lymphocytes in the course of 2 days. Other authors also believed that plasma cells can arise in four different ways: (1) from lymphocytes only; (2) mesenchymal elements only; (3) from both lymphocytes and mesenchymal cells; and (4) independent of other cells.

McMillans has described plasmacytes of two different types and origins, the lymphocytic plasmacytes and the blast cell plasmacytes. Tompkins showed that the small lymphocytes with atypical nuclei can metamorphose into plasma cells; he believed that the transformation begins entirely within the atypical nuclei and spreads to the cytoplasm only secondarily. Marschalko also believed that the nucleus was important in the differentiation of plasma cells, basing this conclusion upon mutually supportive histochemical and morphologic transitions.

Jackson and associates noted the similarity of multiple myeloma to lymphomas and wrote: "The type cell (plasma) belongs beyond question to the lymphoid series and the clinical picture finds analogies throughout its course in the pathologic and symptomatic picture of the lymphomata." Maldonado's group demonstrated intermediate forms of lymphocytes and plasma cells by electronmicroscopy. Lympho-plasmacytoid cells have been observed in cultures of small lymphocytes obtained from human peripheral blood.

Bartfield and Juliar seem to support the contention that it is probable that the apparent variety is merely due to anaplastic changes in one fundamental cell type. Osserman favors the thesis that the characteristic myeloma proteins are products of abnormal plasma

cells. The observation of similar abnormal proteins in occasional cases classified histologically and clinically as lymphosarcoma and lymphatic leukemia suggests that these neoplastic cells are functionally related to the plasma cells of myeloma.

Sundberg has stated that lymphocytes and plasma cells often occur together in lymphatic tissue, the bone marrow, in connective tissue, and in the blood. Immature forms of both lymphocytes and plasma cells show morphologic similarities which have been appreciated for many years, and even mature-appearing lymphocytes seem capable of transformation into plasma cells.

Because of the extensive evidence pointing to lymphocytes as the origin of the plasma cells, we believe that malignant diseases of lymphocytic nature, such as demonstrated in our two cases (chronic lymphocytic leukemia and lymphosarcoma), can terminate in multiple myeloma. Custer and Bernhard and Craver were of the opinion that Hodgkin's disease, reticulum cell sarcoma, lymphosarcoma, and lymphatic leukemia were all mesenchymal tumors which varied only in degree and type of differentiation. They noted that at one time or another during their clinical course, these diseases may present different cellular expressions and morphology. These transformations were detected because of the prolonged clinical courses, permitting frequent follow-up examination of the bone marrow, lymph nodes, and other tissues in addition to alterations of proteins and development of skeletal lesions.

The myeloproliferative syndrome comprises an interrelated group of diseases involving hematopoietically active cells. Clinical experience has shown innumerable instances where it has been impossible to strictly categorize a patient's morphologic findings into a specific entity. Also, in following a patient's course, even without the interfering aspect of therapy, the classical findings of a well-known disease such as polycythemia might be followed by the classical manifestations of myelogenous leukemia.

A clearer way of viewing this situation is through the observation that a stimulus or stimuli act on the hematopoietic elements, be they in marrow or in the widely dispersed reticuloendothelial tissues, to give a spectrum of diseases which, at different stages in clinical evolution, may fulfill the criteria of clearly defined individual diseases.

Noting that the lympho-proliferative syndrome now is generally recognized to encompass the various malignant lymphomas and lymphocytic leukemia, and that the plasma cells arise from lymphocytes, it is an easy step to include these disorders within the lympho-proliferative syndrome. Dameshek and Gunz have called this group of diseases the immuno-proliferative syndrome. It is not known what single stimulus or group of stimuli initiate the abnormal processes giving morphologic and clinical derangements in these patients. This group of diseases can be broadened to include the benign hyperplastic conditions involving the lympho-plasma-reticulum cells as well as the progressive and obviously malignant processes.

A recent clinicopathological conference report in the *British Medical Journal* discussed a case of Waldenström's macroglobulinemia treated with Chlorambucil®. After a short time, increased numbers of plasma cells were noted in the bone marrow. One of the discussants mentioned the possibility of therapy acting to produce an alteration of lymphocytes into plasma cells. Since our own two cases also were treated with cytotoxic agents, namely Chlorambucil® and Cytosan®, we must consider that these may serve as the stimulus, or as an added stimulus, to initiate or hasten the morphologic transformation of lymphocytes into plasma cells. However, attribution of this transformation to cytotoxic agents alone is difficult, since they are widely used in treating lymphatic malignancy; thus one would expect to see this transformation more commonly. Perhaps a greater awareness of this change will demonstrate more cases.

Table
Distinct Disease Entities Within The
Lympho-Plasma-Reticulum Cell
Proliferative Syndrome

Thymic lymphoplasia	
Lymphocytic leukemia—	acute
	chronic
Malignant lymphoma—	giant follicular lymphoma
	small cell lymphosarcoma
	large cell (lymphoblastic) lymphosarcoma
	Hodgkin's disease
	Reticulum cell sarcoma
Symptomatic monoclonal gammopathies	
Asymptomatic monoclonal gammopathies	
Multiple myeloma	
Amyloidosis	
Auto-immune or collagen diseases	

Summary

Multiple myeloma is a malignant neoplasm of the plasma cell series, usually diagnosed on the basis of clinical signs and symptoms and confirmed by bone marrow aspiration or biopsy of an affected bone. There is frequently weakness, weight loss, bone pain, anemia, bleeding tendency, lytic lesions of the skeleton and presence of abnormal protein components in the blood and/or urine. This paper describes two patients in whom myeloma was preceded by malignant disease of lymphocytic series. Transformation of lymphocytes to plasma cells has been described by many authors. Clinicians should be alerted to the possible transformation of a malignant lymphoma to multiple myeloma. The possible implication of chemical agents potentiating this change is discussed.

A bibliographic listing of 48 citations is available from the author upon request.

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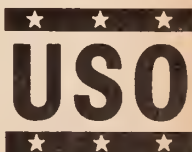
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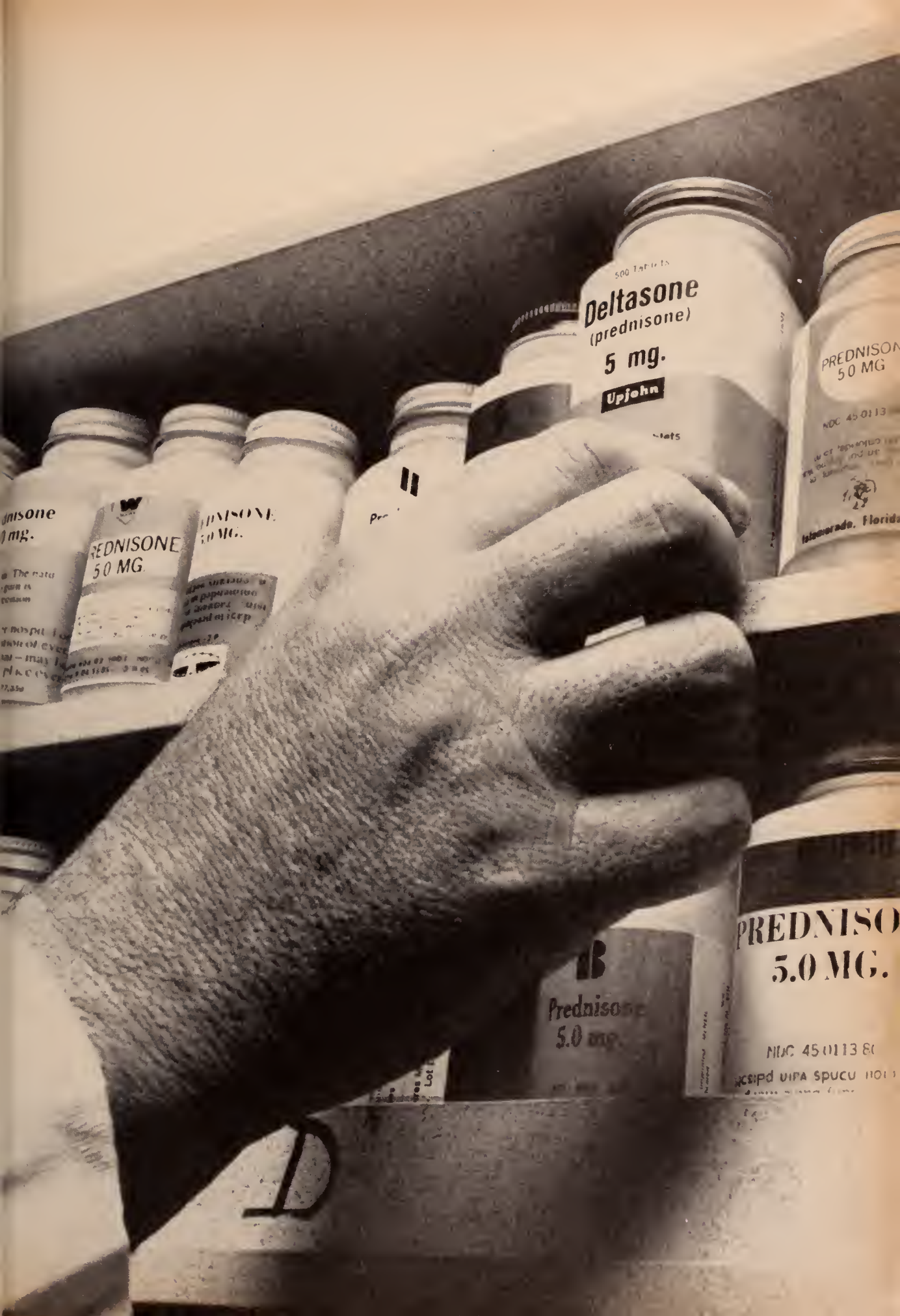
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Contraindications: As for all other corticoids. **Considered Absolute**—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. **Considered Relative**—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccination, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and post-operative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective mainte-

nance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9- α -fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoid during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery, severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fracture; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

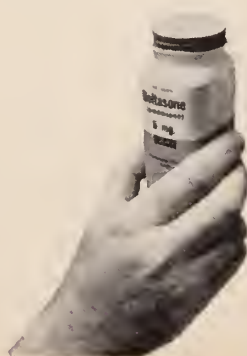
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All of us are now expected to know something about common pesticides. Here you are provided with a unique primer.

Physicians' Pesticide Primer*

Donald S. Kwalick, M.D./Trenton

In suspected pesticide poisoning your State Department of Health offers services essential for confirmatory diagnosis. These services include:

1. Determinations of serum and RBC cholinesterase in suspected organophosphate or carbamate intoxications;
2. Analyses of serum, urine, and gastric contents for identification of various pesticides or their metabolites; and;
3. Identification of whether unknown substances suspected of poisoning a patient contain pesticides.

In suspected pesticide poisoning, collect the following specimens as soon as possible during treatment: (1) Blood—heparinized and clotting; (2) Urine; and (3) Gastric Contents—if ingestion is suspected.

Refrigerate all specimens but *don't freeze them*. Telephone the Pesticide Project—Area Code 609-292-7608, Monday through Friday, 9 a.m. to 5 p.m. After hours, call 609-392-2020.

The New Jersey Community Study on Pesticides (hereafter referred to as the Pesticide Project) is sponsored jointly by the Office of Pesticides and Product Safety of the Federal Food and Drug Administration and the New Jersey Department of Health, and is part of a nationally coordinated study in fifteen states.

The acute effects of pesticide poisonings are well understood, but the effects of long-term, low-level exposure are unknown. To determine whether chronic effects exist, the Project has selected 200 individuals (farmers, pest control applicators, aerial applicators, and formulators) who are occupationally-exposed

to high levels of pesticides. If these persons do not demonstrate any effects from prolonged exposure, then the general population whose exposure is far less should show no effects. These persons are compared with a group of 50 minimally-exposed "controls" for any differences in blood and urine biochemistry, renal and liver function tests, complete blood counts, urinalyses, pesticide residues, and physical signs or symptoms. Each subject is given an annual physical examination, an electrocardiogram, and a chest X-ray.

The Pesticide Project has found, as would be expected, that persons exposed to pesticides in their occupation have higher serum residues of pesticides than general population or control individuals. For example, the mean residue for DDT in our exposed industrial population is 28.8 ppb†, while in the minimally-exposed and general population it is 4.4 ppb†. Thus far, no *abnormal* biochemical chronic changes have been found in the exposed individuals compared with our minimally-exposed control group. However, comparing 40 controls with 52 exposed (farmers and pest control operators) disclosed a statistically significant difference in the number of individuals with hearing and eye problems, chronic cough and sinusitis, dizziness and headaches, and hypertension.

The acute toxicity of pesticides varies from very mild to extremely high. The relative differences are seen in Table I, which pre-

*Dr. Kwalick is Director of our State Health Department's Community Study on Pesticides. This comes from material presented as a scientific exhibit at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, New Jersey, May 16-19, 1970. The work was supported by the U.S. Department of Health, Education, and Welfare; the Public Health Service; and the Food and Drug Administration.

†parts per billion

Table I
General Guide for Estimating Lethal Dose of
*Poisonous Substances***

Acute Toxicity Rating	Acute Oral LD ₅₀ Any Animal (mg/kg)	Probable Lethal Oral Dose of Technical Grade Material for Human Adult
extremely high	5	few drops
high	5-50	"a pinch" to 1 teaspoon
moderate	50-500	1 teaspoon to 1 tablespoon
mild	500-5,000	1 ounce to 1 pint (lb.)
very mild	5,000-15,000	1 pint to 1 quart (2 lb.)

**This table has been adapted from *Clinical Handbook on Economic Poisons*, Hayes, W. J., Jr., United States Public Health Service Publication No. 476, reprinted January 1967, p. 4.

seats a general guide of lethal dose for any poisonous material. Many compounds are best classified by generic and/or chemical type. The most commonly used pesticides in New Jersey and their relative toxicity are presented alphabetically in Table II.

crease in the use of less persistent compounds such as carbamates and organophosphates. Although less persistent, the organophosphates include some of the most dangerous chemicals known to man. An increased number of poisonings with possible fatal outcomes can be expected with the anticipated rise in organophosphate usage unless there is stringent control on the purchase and use of these substances, and unless there is intensive education of the public and many occupationally-exposed individuals.

The pharmacology, onset, signs and symptoms, and treatment of the more common pesticide poisonings are summarized in Table III.

Many clinical effects of pesticide poisonings are similar but treatment varies. In any

Table II
Commonly used Pesticides in New Jersey—Type and Relative Toxicity

Generic and/or Chemical Type	Common Examples		Acute Toxicity Rating
Anticoagulant rodenticides	Warfarin		mild—depends upon dosage
Arsenicals & other heavy metals (Hg, Pb, Cu)	Arsenic Arsenic Trioxide Sodium Arsenite		extremely high
Botanical insecticides	Cube Derris	Pyrethrum Rotenone	mild
Carbamates	Carbaryl (Sevin) Ferbam Maneb Furan Zectan	Nabam Zineb	mild to moderate
Chlorinated Hydrocarbons	Aldrin Dieldrin Endrin Benzene hexachloride (BHC) Chlordane	DDT Toxaphene Heptachlor Lindane Methoxychlor	very mild to high
Herbicides (chlorophenoxy)	2,4-dichlorophenoxyacetic acid (2,4-D) 2,4,5-trichlorophenoxyacetic acid (2,4,5-T) (MCPA) 2-Methyl-4-chlorophenoxyacetic acid		very mild to mild
Organophosphates	Chlorthion Decapthon DDVP (Vapona) Diazinon	Malathion Parathion Phosdrin TEPP	moderate to extremely high

Organophosphates have caused over 60 percent (52 of 82) of the reported pesticide poisonings. Since 1967 the number of organophosphate poisonings has greatly exceeded poisoning from other pesticides. With the decreased use of persistent pesticides (such as DDT) there will be a corresponding in-

poisoning where ingestion is suspected, gastric lavage with several liters of water is indicated. If the patient is conscious, an emetic may be administered or sodium sulfate catharsis may be useful. Therapy should not await laboratory confirmation, but begun at the earliest suspicion.

	CHLORINATED HYDROCARBONS	CARBAMATES	ORGANIC PHOSPHATES
ONSET OF ACTION	Thirty minutes to several hours	Fifteen to thirty minutes to one to two hours	Minutes to several hours - usually very rapid.
PHARMACDLOGY	CNS depression &/or stimulation (varies)	Reversible cholinesterase inhibition	Irreversible cholinesterase inhibition
ABSORPTION	All portals except skin with Dilan and DDT	All portals including skin	All portals including skin
ACUTE SIGNS AND SYMPTOMS	General: apprehension headache nervousness respiratory failure weakness Castrointestinal: anorexia nausea vomiting diarrhea Neuromuscular: coma convulsions muscular twitching & fibrillation paresthesia tremors	General: giddiness headache lightheadedness nervousness Cardiovascular: bradycardia bounding pulse decreased blood pressure palpitation Clandular: salivation sweating lacrimation Castrointestinal: abdominal cramps nausea vomiting diarrhea Neuromuscular: arreflexia coma convulsions miosis blurred vision fibrillation tremor Respiratory: cyanosis dyspnea pulmonary edema	
T R E A T M E N T	GENERAL SPECIFIC	See Organic Phosphates	Maintain patent airway Suction excessive secretions Artificial respiration if necessary Oxygenation to overcome cyanosis Gastric lavage as indicated Decontamination of skin, hair & nails with soap & water followed by alcohol sponging
	For control of convulsions use sodium pentobarbital p.o., i.m., i.v. ? sodium phenobarbital ? calcium gluconate ? valium	Atropine sulfate p.o. or i.m. 1-4 mg depending upon severity of symptoms	Severe Cases: Atropine sulfate parenterally 2-4 mg. q. 5-15 min. until atropinized (dry, warm skin & tachycardia) Child dose .015-.05 mg/kg. Pralidoxime(2-PAM) 1-1.5 gram deep i.m. or i.v. Child dose 25-50 mg/kg May double doses if necessary Milder Cases: Atropine 1-2 mg p.o. or i.m. q.h Pralidoxime(2-PAM) 1-2 gram p.o.
	CAUTIONS & CONTRAINDICATIONS	Pralidoxime (2-PAM) is <u>NOT</u> recommended Tranquilizers, aminophylline, morphine contraindicated	Observe closely 24-48 hrs. after symptoms subside Handle contaminated materials carefully Discard contaminated clothing carefully Phenothiazines, aminophylline, morphine, theophylline contraindicated

TABLE III. ONSET, PHARMACOLOGY, SIGNS & SYMPTOMS, & TREATMENT OF COMMON ACUTE PESTICIDE POISONINGS

Selected Bibliography

For those interested in more extensive reading on pesticides, a selected reference list is included below.

1. *Biological Effects of Pesticides in Mammalian Systems*, Annals N.Y. Acad. Sci., Vol. 160. Art. 1 (June 23, 1960), Price \$23.
2. *Cleaning Our Environment, The Chemical Basis for Action*, pp. 195-244, Sept. '69, Price \$2.75.††
3. *Clinical Handbook on Economic Poisons, Emergency Information for Treating Poisoning*, Hayes, W. J., Jr., PHS Publ. No. 476, Reprinted Jan. '67, Price 55 cents.***
4. *Health Aspects of Pesticides*, monthly abstract bulletin from Pesticides Program of FDA, Price \$6.50 per year.***

5. *Organic Pesticides in the Environment*, Advances in Chemistry Series, 1966, Price \$8.50.††

6. *Pesticides Monitoring Journal*, monthly journal from Pesticides Program of FDA, Price \$1.75 per year.***

7. *Report of the Secretary's Commission on Pesticides and Their Relationship to Environmental Health*, Dec. '69. Price \$3.***

8. *Safe Use of Pesticides*, a manual for public health personnel, 1967, APHA, 1740 Broadway, New York 10019, Price \$3.

††Available from American Chemical Society, 1155 Sixteenth Street, N.W., Washington, D.C. 20036.

***For Sale by Superintendent of Documents, U.S. Government Printing Office, P.O. Box 1540, Washington, D.C. 20402.

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INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

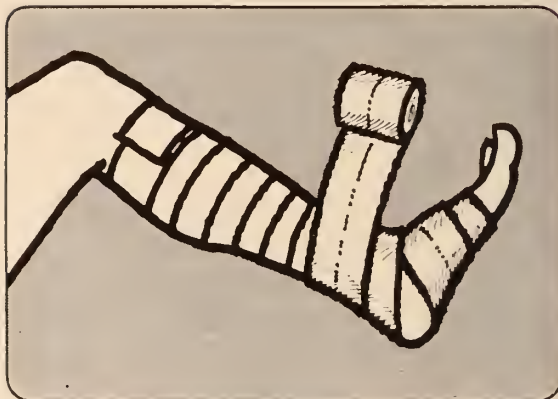
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

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Suppositories (aminacrine hydrachlaride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.14 Gm.)

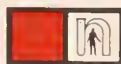
Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

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Duplicate bridge as a therapeutic experience! So suggests Dr. Kuvin.

Personality And Duplicate Bridge

Seymour F. Kuvin, M.D./Newark

Duplicate bridge presents many opportunities to study psychodynamics and psychopathology because of the emotional interaction inherent in this pastime. It is a competitive sport, structured so that the same bridge hand is replayed by all (or most) of the team pairs in the competition. The hands are pre-dealt and inserted into a carrier, which is passed from table to table after each play. The team achieving the best result wins.

Almost empathetic cooperation is necessary between partners for them to win. They must communicate values and "shape" of hands to each other during the auction so as to reach an appropriate contract. This communication must continue during the play of the hand. Communication between partners is a key factor throughout the game, and it is often hampered or enhanced by the personality structures of the partners.

The Role of Aggression

Aggression is a forceful and goal-directed action, which may be healthy, realistic, and constructive when it is used as a problem-solving measure and defense against attack.¹ Aggression at the bridge table is a healthy pursuit as opposed to the pathological self-destructive outcome of unresolved unconscious conflicts. Hence, the duplicate bridge tournament may prove to be a therapeutic experience. Problem-solving ability may be impaired, however, when the aggressive drive is released in verbal or even physical rage. The experienced bridge player is well aware of this fact. Part

of his expert ability is his efficient use of aggression in solving the problems at hand and winning the game, instead of attacking his (apparently erring) partner. This latter behavior only serves to destroy self-esteem and to prevent the partner from using logical thought, thereby clouding intellectual ability and impairing team efficiency. Acute anger also produces the somatic symptoms of muscular tension, and gastric and vasomotor phenomena, which may produce considerable discomfort and thereby detract from the pleasures of the sport.

Aggression is an inborn drive of the greatest clinical significance (along with sexual drive). It is given prime consideration here, but passivity must be mentioned as a behavior pattern of a converse nature. Aggressiveness and passivity have been described to be of a sex-linked nature which is both biologically and culturally determined. Men are characterized in their social and cultural roles as having a higher degree of aggressiveness, and, according to many bridge experts, are stronger players as a rule than women, who are more passive, needing to receive and be dependent. However, there are many women who have achieved greater status as bridge experts than men of lesser ability.

The Effect of Affects

The spectrum of affective behavior is experienced by most duplicate bridge players during a tournament. Anger is an expression of aggression, and, when directed at one's partner, may impair communication and judgment. Similarly, dejection or shame may

affect team performance. There is a diminution of self-esteem and confidence which may occur after errors in play. This will also impede efficient, constructive, and goal-directed action necessary for winning performance. Other affective behaviors experienced are those of guilt, euphoria and, of course, the most prominent one of anxiety.

Anxiety represents emotional pain. This unpleasant affect results from unconscious conflicts between repressed drives and the forces that find them unacceptable. The accompanying body sensations of palpitation, perspiration, headache, the urge to void, and tightness in the chest certainly will add to one's discomfort and impede winning action. However, to some degree, anxiety can be beneficial in play. Mild anxiety warns of impending danger, and enables the player to take the necessary steps in dealing with a threat. Hence he will be wary and on guard, and more able in his offensive and defensive action.

Psychopathology

The impact of psychopathology is too overwhelming to be considered in any depth in a paper of this length. However, one key example may help demonstrate how psychopathology may be underscored and divulged in tournament play.

Many expert bridge players have obsessive-compulsive facets to their personality structure. The defensive mechanism of isolation with total repression of an impulse and its associated affect (leaving only the affectless idea remaining) may prevent discomfort and interference with winning play. The player regularly adheres to the rules agreed upon, without deviation, so that communication is enhanced. Play is efficient, calculated, and cold. It is the consistency and regularity of the play, in this instance, that leads to winning games, rather than flexible innovative style, which may win on other occasions. An obsessive-compulsive player, however, may exhibit a great degree of ambivalence as a result of opposing emotions, ending in doubt so paralyzing that a choice of play, when a close

choice is at hand, is almost impossible. Instead he resorts to a mathematical calculation of choice according to percentage odds. This same player may exhibit a heightened sense of self and of self-criticism in his concerns about hurting others. He may show guilty anxiety which may necessitate some ritualism in order to undo the forbidden acts. Ritualism of various sorts is frequently observed at the bridge table.

Communication

According to the rules and ethics of the duplicate bridge tournament, only limited verbal communication is permitted during the auction. The following words may be used alone or in combination:

Numbers from one through seven

The four suits and "no trump"

Double—redouble—pass

Certain instructional phrases such as "I am about to make a skip bid. Please wait 10 seconds."

All other verbal communication is forbidden because of the inferences created thereby. Hence, "Partner, I'll bid one spade" may be inferential and communicative in an empathetic team. The bid is limited to "One spade," so as not to put the opposition at a disadvantage. Non-verbal communication is strictly forbidden. This ban, however, is almost impossible to enforce because of unconscious efforts at non-verbal communication. For example, the wrinkling of one's brow may communicate information to the partner even though neither player is aware of this fact. In some bridge clubs, efforts have been made to preclude this by a variety of mechanical shields, which have not met with much success. They do tend to impair the intrigue of the game which this author feels is enhanced by these unconscious, involuntary communications. In defensive action and in the play of the hand, communication is by card signals such as "high-low" discards, etc. Movements such as slamming the cards on the table are also barred, but here too non-verbal communication is often unconscious. The challenge of trying to control all com-

munications except those permitted by the rules of the game is indeed a trying one.

“Case Report”

Some actual observations are reported in the following hand auction and play.³

S	K	J	7	6
H	Q	10	8	4
D	5			
C	10	9	5	4

S	9	8	5
H	K	5	
D	A	10	7
C	A	Q	J

N		
W	E	
S		

S	A	4	3
H	A		
D	K	Q	J
C	8	6	2

S	Q	10	2
H	J	9	7
D	4	6	3
C	K	7	3

Vul.—N-S
Dealer—S

South arranges his hand and confidently bids one diamond. There is no overt anxiety. West then hesitates. He is at a loss for a bid. Anxiety produces some irritability, restlessness, and mild increase in perspiration. West is ambivalent and hesitates longer than propriety permits because of his inability to make a decision (and thereby communicating to his partner non-verbally that he probably has the values in his hand for a bid) and finally passes. North responds “one spade” in a flat, unemotional fashion. East then announces “I’m about to make a skip bid—please wait ten seconds. Three hearts.” This is a pre-emptive bid indicating a weak hand, but East may have not made this bid had not West communicated (consciously or unconsciously) his values. East quickly realized what he did, and his facial expression and manner conveyed some guilt and shame. He remained motionless until South called the tournament director, at which time a

flush crept over East’s face. South then protested West’s hesitation in an aggressive fashion, producing further anxiety and its resultant somatic manifestations in West and also in East. The bidding was reviewed and then the director allowed the bidding to continue, and stated that if the N-S team was harmed by the hesitation he would rule further. South, at this point, became angry, and his judgment was so clouded that he passed. The other players passed in turn. East played the contract in three hearts, and by careful play only missed his contract by one trick. This resulted in a good score for the E-W team. South’s anger permitted him to defend in only a mediocre manner. After the play, the director was recalled and the E-W team was summarily penalized inasmuch as the N-S team was declared to have been harmed by the bidding. The N-S team’s aggressions were satisfied. E-W team was embarrassed with some degree of guilt manifest in East.

Summary

Bridge, especially duplicate bridge, is a game filled with emotional expression. Clues to personality structure and psychopathology are often disclosed. It is postulated that this game could be used in a diagnostic or therapeutic setting in group situations, as other games and devices have been used in the past. Institutions and therapeutic communities are particularly suited to using this game as an expressive and communicative aid.

References

1. Linn, L.: “Clinical Manifestations of Psychiatric Disorders.” In *Comprehensive Textbook of Psychiatry*. Freedman, A. M., and Kaplan, H. I. Baltimore, 1967. Williams and Wilkins.

2. Aldrich, C. K.: *An Introduction to Dynamic Psychiatry*. New York, 1966. McGraw-Hill.

3. Essex Bridge Center. West Orange, New Jersey.

268 High Street

Jersey Medical Women

For 1971, the New Jersey Medical Women’s Association has elected Dr. Myra Zinke of Holmdel as its new President. Dr. Zinke, who is Vice-President of the Monmouth County Medical Society, is a Board Certified internist and is a Fellow of the American College of Physicians. Her particular interest lies in liver disease, especially in its relationship to hepatitis and alcoholism.

Other officers sworn in with Dr. Zinke are as follows. President-Elect, Dr. Berta Rados, Irvington; First Vice President, Dr. Satty Gill Keswani, Livingston; Second Vice President, Dr. Nancy Durant, Plainfield; Treasurer, Dr. Hilde Baruch, Elizabeth; Recording Secretary, Dr. Barbara Solemone, Clifton; and Corresponding Secretary, Dr. Sandra Weiss-Schwartz.



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urinary tract infections
septicemia
abscesses
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* due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status — urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children — not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



100913



Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

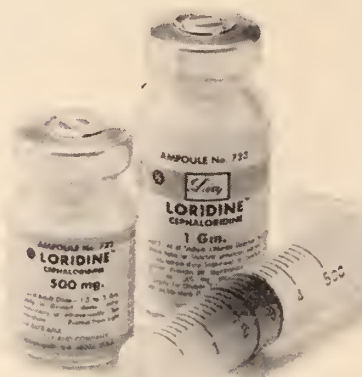
Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

Loridine® CEPHALORIDINE



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinistest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

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Additional information
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Continuing Physician Education in the Community Hospital

Introduction

James A. Rogers, M.D., Paterson

Report of Symposium Held on October 7, 1970*

Hospital's Role in Continuing Physician Education

John G. Freymann, M.D., Hartford, Connecticut

Medical School's Role in Hospital Education Program

Frank M. Woolsey, Jr., M.D., Albany, New York

Linking the Hospital and the Medical School

Ashton B. Morrison, M.D., New Brunswick, New Jersey

The Medical School in Meeting Community Health Needs

Rulon W. Rawson, M.D., Newark, New Jersey

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Panel Discussion

Hospital Administrator's View of Continuing Physician Education

Edward J. Dailey, Jr., Plainfield, New Jersey

Hospital Trustee's View of Continuing Physician Education

John L. Sinn, Manhasset, New York

Improvement of Patient Care

Warren B. Nestler, M.D., Summit, New Jersey

Third Party Payer

Joseph P. Donnelly, M.D., Newark, New Jersey

Cost of Medical Education in Community Hospital

Robert L. Evans, M.D., York, Pennsylvania

Staff Physician's View of Continuing Physician Education

Arthur Bernstein, M.D., Maplewood, New Jersey

* Sponsored by the College of Medicine and Dentistry of New Jersey and the New Jersey Regional Medical Program. Cosponsors were the Academy of Medicine of New Jersey, The Medical Society of New Jersey, the New Jersey Association of Hospital Directors of Medical Education, the New Jersey Association of Osteopathic Physicians and Surgeons, and the New Jersey Hospital Association. Presiding were Richard I. Cross, M.D., Chairman, Department of Medicine, CMDNJ at Rutgers, and Robert R. Cadmus, M.D., then President CMDNJ at Newark.

Physician Education And The Community Hospital*

On October 7, 1970, a unique symposium was held at the Rutgers Medical School. The topic was "Physician Education and the Community Hospital." The papers and panel discussion heard on that occasion are reproduced below.

Prime sponsors of the program were the College of Medicine and Dentistry of New Jersey and the New Jersey Regional Medical Program. Cosponsors were our state's Academy of Medicine, the Association of Directors of Medical Education, the New Jersey Osteopathic Association, the New Jersey Hospital Association, and The Medical Society of New Jersey. By way of background, James A. Rogers, M.D., for the Regional Medical Program, has prepared the following introduction from a survey he made in 1969.

The community hospital is becoming the focal point of health care, involving the knowledge and skills of the physicians, nurses, and paramedical personnel who must interact in an organized fashion to bring about better patient care. Continuing medical education simply must be made an important function in the community hospital. Here, medical staffs can secure continuing education with the least disruption of their professional schedule. It is at the community hospital that physicians do much of their problem solving, and here is where the records of their results may be used as staff assessment tests. These tests and other medical audits will help to determine educational needs of the staff and to prepare continuing educational curricula.

The medical school must link itself to the community hospital in graduate educational activities to reach the practicing physician. This relationship is an effective way to transmit medical knowledge. This seminar points out that strong bonds must exist between the medical school and community hospitals. The medical school will look to the community

hospital for clinical teaching material and the hospital will look to the medical school for direction in continuing physician education.

New hospital affiliations with the medical school will produce more hospital beds for the teaching of more medical students without vast capital outlays. It is important effectively to utilize present facilities.

An analysis of the data from the Survey of Continuing Physician Education in New Jersey Hospitals discloses:

1. Many hospitals are now becoming medical centers with more involvement in community health care.
2. A lack of consideration given to allocation of funds by Boards of Trustees of community hospitals for Continuing Physician Education.
3. An increasing number of hospitals that are supporting family practice programs.
4. An increasing number of geographically full-time physicians in hospitals, and of hospitals with Directors of Medical Education.
5. An attempt to obtain greater participation and involvement on the part of the medical staff in the teaching program.
6. An increasing trend from solo to group practice.
7. Decreasing interest of many county medical societies in Continuing Physician Education.
8. Variation in attendance and response on the part of physicians to programs may be traced to the lack of the elaboration and quality of the programs offered.
9. The lack of coordination and organization of educational programs on a state-wide basis.
10. A shortage of experienced educators in medicine needed for the programs in the community hospitals.
11. Increasing involvement of a third party in compensation matters.
12. Problems of accreditation, relicensure, and recertification which are rapidly becoming omnipresent threats and opportunities.

Our over-all plan designed to coordinate and

*Reprints of this entire section (11 articles plus panel discussion) are available in brochure form upon request from the New Jersey Regional Medical Program, 7 Glenwood Avenue, East Orange, New Jersey 07017.

supervise Continuing Physician Education in New Jersey is as follows:

1. The basic unit in the plan will be a community hospital of 300 or more beds, as well as two or more hospitals totaling 300 beds in close proximity. Each unit will have a Director of Medical Education. The faculty will include knowledgeable and interested physicians on the medical staff. The curriculum will consist of topics of broad medical interest, of advances in basic sciences as they relate to disease, diagnosis, and treatment, as well as needs of the staff, detected through audits and assessments. The educational activities of the hospital will be open to all physicians.

2. The specialty societies will prepare programs for interested physicians on a regional basis. These programs will be coordinated and supervised by the new department.

3. A Department of Continuing Physician Education must be established by the College of Medicine and Dentistry of New Jersey to coordinate and supervise the entire plan. It will cooperate with the specialty

societies, as well as with the basic units throughout the state. It will supply, when requested, expert medical talent to the basic unit to act as visiting teachers, to take part in clinical pathological conferences, in grand rounds, and in portions of the teaching programs.

The liaison between the Department of Continuing Physician Education and the basic units will be through the Directors of Medical Education. They will have teaching appointments at the medical school.

It is the purpose of the plan effectively to utilize the facilities of the medical communities of the state in a cooperative way, to prevent duplication, and to improve the quality and methodology of the educational programs in the community hospitals in an attempt to provide good patient care.

Role Of The Hospital

John G. Freymann, M.D., Director of Education
Hartford Hospital, Hartford, Connecticut

Let me set the keynote by dividing medical education into four phases. First is that dreary old course way off somewhere. Second is the shotgun lecture in a hospital setting. The third phase is the linking of education with quality of care in the hospital. The fourth phase (which we have not yet developed but which we might think about) is "the extension by the hospital of continuing education from just education for hospital care to true education in health care."

At one time the first phase did serve a great function. There were no other educational facilities so that the physician had to go some place to take a course, and I think some of those were excellent. But generally the effort involved in them wasn't worth the payoff. They were exciting but the long term results of going out of town to attend a course are not very valuable. They don't last. When one goes off to a course, there is also the competing attraction of the nearest beach or golf

links. One possible exception is the proposal for prolonged retread training in a hospital atmosphere. Still, this is taking the physician and putting him in an environment foreign from that in which he usually practices so that I would say that going away some place for continuing education is now an obsolete concept. In truth, the hospital is the proper place for continuing education. A process of continual intellectual replacement is possible in a hospital atmosphere. This is where the physician works; this is where the physician is available daily; and this is also where the physician can feel the pressure of his peers.

In Great Britain medical schools are based in hospitals. The university has been a late-comer in medical education in England. The hospital would also be the base of medical education in this country if it were not for the historical accident that the founders of our first two medical schools, John Morgan in Philadelphia and Samuel Bard in New York,

happened to get their medical education not in the hospitals of London but the University of Edinburgh, so that when they returned to this country, they copied the university system of Scotland rather than the hospital system of England as a basis for education. Had it not been for this, and had they gone to London for their education, I rather expect our hospitals, the Massachusetts General, the Columbia Presbyterian, and various places such as the New York Hospital and the Pennsylvania Hospital, would be the medical schools.

There was a long hiatus from the founding of the first medical school in this country to the time when quality entered medical school education. This gap was from 1765 (the year in which the University of Pennsylvania was founded) to 1910 when Abraham Flexner wrote his famous report. The same historical gap existed in the quality of hospital education. I am talking now about community hospitals, from the very early days when medical education moved out of hospitals and into universities until around 1945 when Hartford Hospital was the first community hospital in the country that established a full-time physician with the responsibility of medical education of both graduate students and staff physicians.

This brought us into the second phase. That is the shotgun lecture stage. This was a great advance because it brought into hospitals what had not existed before: a formal educational program. At this time, a quarter of a century ago, most staff and house physicians were undifferentiated. Of course, we had surgeons and internists, but the hyper-specialization of today did not exist. A shotgun lecture is what I am doing here today. We are shooting one subject at you and the chances are it will hit a lot of you. Twenty-five years ago, and to a certain extent today, you could take the entire staff of a hospital and lecture to them and hope to get somebody. But the chances of hitting a large proportion of the audience become less and less if hospital staffs become more fragmented by specialization. Indeed, one of the direct re-

sults of this introduction of educational milieu in the hospital was specialization, then the development of full-time chiefs, more full-time staff, and departmental rather than hospital teaching programs. We have now reached the point at the Hartford Hospital where it is practically impossible to get the entire staff together because 90 per cent of them are not interested in whatever subject you have to offer. The only common denominator of interest to everybody in the staff is the socio-economics of medicine. Other than that, specialization has all but eliminated any chances of functioning with a shotgun approach to education.

The third phase began when educators started to ask the nasty question, "You are teaching, but what is being learned? You have a great program, but what evidence do you have that you have changed anyone's behavior?" We have gone on the assumption that education was good with a capital G. Education is an end in itself. Well, it isn't. I can stand up here all day, but if I do not change anybody's ideas and eventually lead to a change in behavior, I am wasting my time and you are wasting yours. This has bothered many educators in medicine who are scientists in the laboratory, who would never think of performing an experiment without carefully evaluating their results, and on the basis of this evaluation deciding whether they had accomplished anything. Yet they may walk from the laboratory into the lecture hall and take umbrage at the idea that anyone should evaluate what they are trying to get across to an audience.

In this third phase our prime objective is to evaluate what people are learning. We have to link the quality of care with education, some connection of which is so obvious, but it hasn't been thought of before. What we are starting to tackle now is to take peer groups, that is the staff of a hospital, to establish performance criteria and then work out methods for evaluating the care of patients on the basis of these criteria. Norms must not be set up by some outsider, but by the staff of the hospital itself.

On the basis of this evaluation of care, we must identify gaps in the quality of care as rendered in the hospital, and then design specific educational treatment to heal these gaps. This is the antithesis of the shotgun approach. Instead of giving a lecture on the latest concepts, we take something which you, as a staff, will fail to do (or not do as well as you can do) and then design an educational program to meet that specific need. This has the great advantage of being relevant, which the shotgun approach is not to most people, and also in making the audience active participants in the process, because you are talking about the care of their patient not what is being done at the nearest medical center. You are talking about their problems.

You are not only evaluating care, you are evaluating the efficacy of your teaching. After all, getting the staff to read an abnormal urinalysis report and then act on it is really quite an educational problem. It is aimed at a demonstrated need: the staff was not properly reading the urinalysis reports. It was not involved in, say, discussing renal transplantation which is several steps down the pike from reading urinalysis. Well, as I say, this phase (which is developing now) is tremendously exciting because it means that we are finally linking education with the quality of care. This involves the objective evaluation of both. This is feasible only in a hospital and only if the staff participates, because the staff has to set up the peer criterion. The responsibility of the hospital is to support it, to provide the clinical staff, the computer staff, and so forth, so that every possible means is given to advance this educational process. The staff must want to do it. It cannot be jammed down their throats by hospital administration. True, doctors are not clerks. If you plan to evaluate the quality of care by having doctors read records that a clerk could read, then forget your program.

The fourth phase is still very much on the horizon, because the third phase is limited to what is going on in the hospital. The hospital is a passive receptacle that receives people who have the means and the motivation to

come to the hospital and ask for aid. Education, limited to this biased small population, falls victim to what I might call the Kerr-White phenomenon. The Kerr-White survey, done many years ago, showed that out of a population (now this is not a population of sick people) of a thousand people during a single month, 750 of them will have some form of illness or injury. Two hundred and fifty of them will see a doctor. Five of them will enter a community hospital. Only one of them will enter a university teaching hospital.

Education based on a hospital population is thus restricted. If you are in a university hospital, it involves one tenth of 1 per cent of the population. In a community hospital, we are talking about four tenths of 1 per cent. This phase of continuing education is going to involve the hospital's asking, and the medical staff's asking, "What is good medicine?" Perhaps we are arriving at the point where our criterion will be that it is poor medicine for a patient to have had a coronary in the first place, and we may arrive at the day when we look at our hospitals and say that these are monuments to the failure of our health care system, because they shouldn't be there if the health care system was working right.

When continuing education gets outside of hospital walls, it will then get into a harsh world where diseases are not selective; where you cannot arbitrarily exclude the senile, the psychotic, or the chronic invalid; where problems are multifactorial; where they are biologic, psychologic, sociologic, and economic; where failure in medical care is the occurrence of acute disease. When we get continuing education out into this world, it will no longer be confined to the narrow limits that are now set on undergraduate and graduate education.

When continuing education gets beyond hospital walls but is centered on health centers, it will still have to have a base. Then we will be entering into a broad educational field where it will not only have to meet the reparative requirements of the practicing physi-

cian, but where there will be no limits, because we will then have to be teaching biomedical advances, psycho-social advances, and political-economic advances. When we reach this stage, continuing education will be stimulating for it will be something new, not

just going over the same old things you have forgotten since you left medical school. Then when we talk about continuing education to the physicians of the future, we will not, as I am afraid we do now, give a lot of our listeners indigestion.

The Medical School's Role In The Hospital Education Program

Frank M. Woolsey, M.D., Associate Dean
Albany Medical College, Albany, New York

Let us use the phrase *undergraduate education* to describe the education received at medical school prior to getting the M.D. degree. Then, we shall define *graduate education* to characterize the education offered after medical school, while the doctor is preparing for general or specialty practice. *Postgraduate education* is the education received following the graduate training, usually while the physician is engaged in the practice of medicine. "Postgraduate education" is synonymous with "continuing education."

An "affiliated hospital" refers to a hospital-medical college relationship in which the medical college is responsible for the quality of the educational program. Because of this responsibility, the hospital grants to the medical college the authority necessary to assure adequate personnel and control over the quality of the program. "Associated hospital" refers to the relationship between a hospital and a medical college in which the hospital retains both responsibility and authority. An association is for the purpose of improving the educational programs, but the responsibility remains with the hospital.

Medical schools have not formalized their role in the education programs of hospitals. Every medical school is affiliated with at least one hospital and some have associations in addition to affiliations.

prime responsibility the education of undergraduate medical students. Medical schools are responsible for this education in its entirety. No one else does it; no one else can do it. The task is great. Schools face the problem of student recruitment, the need for constantly improving the curriculum, increasing difficulty in financing, the need for replacements and expansion of the faculty, involvement of the faculty in graduate education within the affiliated hospital, expanding efforts in continuing education, and now increasing pressures for them to be involved in assisting those of you in community hospitals. Why should they do so?

The entire endeavor, undergraduate, graduate, continuing education, and medical research are of no significance unless the acquired knowledge, experience, and skill are utilized in the prevention, recognition, and management of illness. None of these activities has significance unless it benefits individuals. Community hospitals supply health care to most individuals who need this care. If medical schools are not willing to assist, they attenuate the total potential of all of their efforts and abrogate their responsibilities. If those of you in community hospitals wish assistance from medical schools, they have a responsibility to respond if you meet your responsibilities. Unless you do this the medical schools cannot help you.

Medical educational institutions have as their

It seems likely that the medical centers will

continue to be the source of the development of most of the new knowledge and technics, and the application of the technics to the care of patients. It also seems likely that there will be community hospitals surrounding the medical centers which will assume additional service responsibilities—additional to those they now hold. Abnormalities which had been cared for previously only in the medical center hospitals will increasingly be handled by community hospitals. As change develops, selected community hospitals (or groups of community hospitals) will become area medical centers. For this to take place these hospitals will need to be more clearly identified as area medical education centers. This must be accompanied by an increasing tempo of medical education within these community hospitals.

Community hospitals which develop the best educational programs (either individually or in collectively organized groups) are more likely to be the community hospitals which become the area foci for advanced medical services. It is hard to conceive of any community hospital becoming such a focus unless it becomes increasingly involved in continuing medical education.

If community hospitals are to meet these new responsibilities, if they are to become truly area medical educational centers, a shift in emphasis from delivery of clinical services to a combined objective of patient care coupled with the development of an academic program becomes essential. Physician graduate and postgraduate education must receive higher priority.

If medical knowledge is the essential ingredient in the best patient care, regardless of the skill of application, it seems self-evident that continuing medical education is essential to good patient care. It is also evident that the teacher who continues to be a student is best prepared to be a teacher. Teachers will be needed for the educational programs of New Jersey hospitals if the New Jersey hospitals are to be capable of assuring the highest quality of patient care. Proper conduct of

graduate training programs may result in patient care which is of higher quality than could be obtained without these programs. This comparison is between the care given within hospitals involved in graduate education and hospitals which neither have graduate programs nor adequate programs of continuing education. This might not be true if the hospitals which do not have interns and residents develop active postgraduate programs. These programs would need to identify practice deficiencies and formulate activities which would allow the deficiencies to be rectified.

Why should the smaller hospitals and the others not in a position to develop into area medical centers be interested in an association with medical schools? The answer is clear. One must laud the physician who has dedicated his life to the community practice of medicine. But such dedication, if it is not tempered with intellectual stimulation and renovation, does not result in the very best of medical care. The best in medical care is based upon the application of integrated medical knowledge. It is much easier to have up-to-date and integrated medical knowledge when assisted by those whose profession is medical education.

If you wish to be involved in internships and residencies, as well as programs of continuing education, remember that the time has almost arrived when (with a few notable exceptions) all graduate training will be in university affiliated or associated hospitals. Certainly this will be true unless the graduate training programs now being conducted by hospitals show a marked improvement without such cooperation.

The medical colleges and their administrators live in a complex and difficult world. They are continuously confronting the problems involved in the selection of medical students in the undergraduate medical college curriculum, in the acquisition of faculty and the expanding needs of graduate medical education, in the increasing demands of continuing education, and in the need to finance all of

these undertakings. When you approach them with your suggestions for association or affiliation, you are often inserting your own difficulties into their problems.

Fortunately an increasing number of medical schools are willing to give serious consideration to what they may do to assist community hospitals. Let me suggest a number of things you should consider in developing such a relationship. First each party must have a clear understanding of the attitudes and the reaction tendencies of the individuals who will be involved. There should then be a formalized outline of goals and a framework for the anticipated program. It is a mistake to become too concerned in advance with the intricacies of the interrelationship. Further, the understanding must be formulated in writing and all commitments must be delineated and approved. Staff members, medical school administrators, and hospital administrators change. The program needs continuity from one administration to the next. There is a need for commitments which are binding on those who are to come. This written record allows everyone an opportunity to know what the association is to accomplish. Actually, the entire agreement does not represent a hazard, since the period of agreement can and should be limited. It is also important to have re-evaluations of the progress of the association at stated intervals. The hospital should be willing to shoulder its share of the financial responsibility involved in this association. It should not expect the medical college to carry this load.

The most disappointing factor has been the unwillingness of the private hospital staff members to accept their individual responsibilities within the educational program. The association is doomed to failure if it is expected that the medical college can do the hospital staff's work. This they cannot do. These associations should not be developed with the concept that the community hospital staff will have less work. Nothing can be done better with less effort when the doing requires human effort.

Community hospitals hold complete authority over the factors which will determine their destiny. This includes the authority to delegate authority. Within the agreement there should be a careful description of how much authority the medical school should have and over what part of the cooperative program.

In our associations at the Albany Medical College with our community hospitals we exert no authority. This is a definite handicap. It is, however, a necessity since many of our associates guard their complete independence with a tenacity which defies description. If they approached their educational efforts with the same enthusiasm with which they guard their independence, they would have no difficulty presenting superior educational programs.

If the hospital authorities are truly dedicated to superior medical care and realize that an association with a medical school will aid them to attain their goal, then they should offer whatever authority the medical college may need to meet the responsibilities within the agreement.

As an example, the hospital could suggest that the medical school and the hospital have equal authority in relation to the appointment of the Director of Medical Education, or the Chiefs of Services. This would allow the medical college to use its knowledge and experience in medical education to help obtain the needed individuals and at the same time allow the hospital authorities to control important moral and social considerations. Furthermore, it is the responsibility of those in authority, the administration, the board of trustees, and the staff to assure full, unstinting, continuing support of the programs of medical education. Medical education is the intellectual foundation upon which are based all of the professional efforts to achieve this goal. There is no other knowledge, no other method, no other way to assure the best medical care. If it is to be done, it must be done through medical education, first in the medical colleges, then in the graduate education

programs, and finally in the lifelong, continuing education of each practicing physician.

It is impossible to overestimate or fully to comprehend the ultimate importance of medical education. The importance to the individual patient is most easily understood. The total effect upon our society and, in fact, upon all people is tremendous and more difficult to appreciate. Knowledge and skills residing within the members of the medical profession are the chief factors in determining

the prevention, diagnosis, and management of disease. This determines the health of our nation. The health of our nation is one of the most important influencing factors in the success of our country. No nation can be dominant in a world society without a dominance of good health. Good health makes for good reason, for objectivity, and for emotional control. These factors are most influential in the determination of whether there shall be suffering or comfort, inhumanity or humanity, war or peace.

The Hospital-Medical School Link

Ashton B. Morrison, M.D., Professor of Pathology
College of Medicine and Dentistry of New Jersey at Rutgers, New Brunswick

The medical school is dependent on the surrounding community hospitals. Thus, we in the Rutgers Department of Pathology use the case method of teaching and do not depend on didactic lectures. We bring the material to the student and let him make his own clinical pathologic correlation.

Let me tell you what has happened here at Rutgers over the past five years by using the case method of presentation and study.

When I came here in 1965 there were no students and the school was due to begin taking students in 1966. We needed access to material for the Pathology Department and we looked to the community hospitals in the neighborhood.

The first community hospitals to cooperate in our program were the two in New Brunswick, Middlesex and St. Peter's. We soon found we had to go further, and began cooperating with Muhlenberg Hospital in Plainfield and Somerset Hospital in Somerville. We had colleagues coming in from a wide area. We had to be assured, too, that we could get suitable transportation. This was in 1965, with but one year to prepare, and we

decided to cooperate with the hospitals on a professional level. We did not seek any formal agreement with the hospital, but we agreed to bring professional people in the Departments of Pathology into our faculty. We had to review their credentials academically, and as a result, there were a few sore noses and a few burnt fingers. However, most of the pathologists in the area were acceptable, and we have welcomed them as faculty members. These people agreed to teach a half day a week without salary. In return for this the University gave them academic titles. The approach of the department is one of standard pathology, except that our cooperating clinical colleagues bring fresh pathologic specimens with them and demonstrate that material to the students.

One part of our program requires the students actually to get into the hospital and assist at autopsies. This was the first place we had to deal with the hospital administrators because questions of insurance and the like came up. What would happen if one of our students were to develop tuberculosis at one of the hospitals' autopsy examinations? Our answer was a very simple letter written to each of the administrators stating that the

school had a responsibility for this, and that there was no responsibility on the part of the hospital. So far, everything has worked well. We have developed stronger relationships with some hospitals than with others, largely because we were able to get space to work in these particular hospitals. We have a very close relationship with Muhlenberg Hospital in Plainfield. We run joint programs and, in general, our relationship there is stronger than in any other hospital. This matter was not of our choice, but it was due simply to the fact that Muhlenberg Hospital had the space available. They wanted to develop a sound program, and we responded. Should any of the other hospitals offer to do the same thing, we would be willing to move ahead in that direction.

Every hospital can contribute something to education. It may have patients with medical problems that are valuable in teaching. This does not mean that we are interested only in an associated or affiliated hospital; it also could be a nursing home.

It is imperative for full-time staff to be present in the hospital if there is going to be

any meaningful relationship. This is quite easy to arrange with pathologists in most hospitals. By virtue of their profession they are educators and teachers, and in many instances they do the teaching in their hospitals. In hospitals which do not have a Director of Medical Education your pathologist is really your Director of Medical Education (if he is a good pathologist). So there is less of a problem in the field of pathology than in the other clinical areas, but it is imperative that the other clinical areas develop full-time people in internal medicine or in surgery if there is to be any meaningful relationship. I am not making a pitch that pathology is a special discipline. This affiliation or association is like a marriage. You can have either a religious ceremony, a civil ceremony, or a loose liaison. There are, of course, the casual encounters, and in many ways, our relationship in pathology has been the latter. It has been an unblest liaison, and it has worked very well with us. What is really needed is a full-time staff, understanding, cooperation, and flexibility on the part of the medical school and the hospitals in making suitable arrangements. From there, I can only advise you to "play it by ear."

The Medical School In Meeting The Community's Health Needs

Rulon W. Rawson, M.D., Dean of Medicine and Vice-President
College of Medicine and Dentistry of New Jersey at Newark

If you look at the health manpower pool of the United States, you will see that there is a critical shortage of physician and health manpower. It has been estimated that we need 50,000 new physicians in the United States today. There are more than 100 counties in the United States which do not have one physician. Many urban centers are in serious need of adequate health care. A major infusion of physician manpower is needed.

New Jersey is worse off than the country as a

whole. The nationwide figure is 135 physicians per 100,000 population. In New Jersey the ratio is 130. Compare these figures with our neighboring states from Massachusetts to Maryland. In Massachusetts there are 188 physicians per 100,000, in Rhode Island 154, in Connecticut 170, in New York 207, in Pennsylvania 138, in Delaware 132, and in Maryland 184. This is an alarming situation and is even more alarming when we recognize that of the 9,100 physicians practicing in New Jersey, a third are over the age of 55.

In Region 3 (Essex County and parts of Union County) 26 per cent are over the age of 60. If we maintain our present level, which is inadequate according to the national average, and certainly very inadequate as compared to the average physician to population ratio in our neighboring states, we will have to bring into the state 300 new physicians a year for the next ten years, just to make up for the attrition of those 3,000 physicians in the state who are now over the age of 55. If we were to bring ourselves up to the average physician to population ratio of our neighboring states, we would have to bring into the state more than 3,000 physicians today. This is not a credit to New Jersey.

In 1969, New Jersey ranked number 5 among the 50 states in the number of students that were accepted into American medical schools. There were 1,001 medical school applicants from New Jersey and 483 or 48 per cent, were accepted by American medical schools. Unfortunately, more than 80 per cent of them went out of state for their medical education. The College of Medicine and Dentistry of New Jersey at Newark, which has a four-year program, was accepting 80 students at that time in the freshman class. At that time Rutgers, still living in small temporary quarters, was accepting only 16 in a class.

Compare New Jersey's performance in medical education with New York and Pennsylvania. We are way behind. In New Jersey, which has a population of 7.4 million, there are two medical schools, one of them a four-year school and the other functioning as a two-year school with plans to expand to a four-year school. In the two schools, as of last year there were 335 students studying medicine. As of this date, this total number has been increased by almost 100 students. Rutgers accepted 80 students into the 1971 freshman class and the College at Newark increased the size of its freshman class from 80 to 85. In Newark we also accepted (on a transfer basis with advanced standing) 12 students who had completed preclinical programs of medical education in foreign schools and who had passed Part I of the National Board Medical

Examination. By comparison, New York, with a population two and one half times that of New Jersey, has 11 functioning schools and one developing school. Eight of these schools are private and four, including the developing school, are state schools. These New York schools have enrolled and are providing a medical-educational program for more than 4,500 students. Pennsylvania, which has a population 50 per cent greater than that of New Jersey, has seven schools, two public and five private. Last year they had enrolled nearly 3,000 students. Most physicians chose the places in which they practice because these communities were close to the institutions where they had had their graduate medical education as interns and residents. This is another critical situation in New Jersey. In 1969, of the 600 approved internships in New Jersey, only 4 per cent were filled through the National Internship Matching Plan. Many have asked why New Jersey has done so poorly in filling its approved internships. I suggest that we might consider the trends in the Internship Matching Plan between 1958 and 1969. In 1958, 48 per cent of all of the approved residencies filled by the N.I.M.P. were those offered by the major affiliated hospitals, whereas 34 per cent of the graduating class of 1958 matched with non-affiliated hospitals.

Ten years later, those matching with non-teaching hospitals represented 24 per cent of all of the internships filled through the N.I.M.P. and 58 per cent matched with major teaching hospitals. In 1969, 63 per cent went to the major teaching hospitals, whereas only 20 per cent went to the non-affiliated hospitals. It is obvious that today's students, upon graduation from medical schools, are seeking internships in hospitals with strong educational programs.

The first time that I, as a Dean, attended a meeting of the Association of American Medical Colleges, Dr. John Deitrick, the Dean of the Cornell University Medical Center, said that medical schools must assume responsibility for developing strong graduate educational programs in hospitals. He strongly urged the Deans to take responsibility for supervising

and following their students through internship and residency training. In 1970 at the meetings of the American Medical Association, the delegates (acting on recommendations made by the Council on Medical Education, the Commission on Graduate Medical Education, and the Board of Trustees of the A.M.A.) passed a resolution that no internships would be approved which could not demonstrate full integration into a fully-approved, total residency program and that in 1975 those self-standing internships shall be terminated. The delegates approved the recommendations (made by the Council on Medical Education, the Commission on Graduate Medical Education, and the American Board of Internal Medicine) that residencies in medicine would be approved only in institutions having full time chiefs of service and teaching staffs. As of now all residencies will be approved on an institutional basis rather than on a service basis. Recently, the Liaison Committee which approves medical schools for accreditation has been expanded to include representatives of the Commission on Graduate Medical Education. Last year, four of the medical schools which were examined by the Liaison Committee for accreditation not only had their undergraduate programs examined very critically but their graduate programs in affiliated hospitals as well. I would predict that in the future, other residency programs, as well as in internal medicine, will be requiring full time core staff physicians to be responsible for their educational programs. We can predict on the basis of what is happening that the recommendation made by Dr. Deitrick before the Council of Deans in 1967 that medical schools take responsibility for graduate medical education (internships and residencies) is actually coming to pass. Within a few years, all graduate educational programs will be under the auspices of our schools of medicine. This will put added burdens on all schools of medicine, but it is a healthy development. I agree with Dr. Deitrick that our academic health centers must involve themselves in the graduate educational programs conducted in hospitals. This will contribute greatly to improve patient care and it will also have a good effect on the colleges of medicine.

The faculties of your two medical schools are committed to assisting in resolving some of the needs for physician manpower of New Jersey. Rutgers Medical School has expanded its freshman class to 80 students and, as soon as possible, facilities will be available so that they can give the full four-year educational program to all 80 students. The College of Medicine and Dentistry of New Jersey at Newark has agreed (assuming that the State provide us with the resources for new faculty and certain changes in our present interim physical facilities) to increase the size of our freshman class from 85 to 110 students. By 1975, we will be expected to accept at least 150 students into our freshman class. This is going to be an expensive task for the State to assume. However, we cannot continue to be dependent upon the private schools outside of New Jersey (which are already in serious financial trouble) to provide medical education for the 400 students going out of New Jersey at the present time. As a matter of fact, I don't see how these private schools can continue without major financial support from Federal and State governments. Already, several states are giving financial support to their private medical schools. Such support is on capitation basis. Some of these states are now insisting that those schools receiving such financial support give preference to applicants from their own states. I foresee that the private schools to which our students are now going are going to ask for more financial support from their State legislatures. I can see the legislatures of these states putting restrictions on such state supported private medical schools by limiting the capitation support to students from their own states.

The faculties of your two medical schools are dedicated to the development of strong educational programs for undergraduate students and to cooperating with those hospitals having the resources and a commitment to education in developing major affiliations and minor affiliations with several of the state's community hospitals. We look upon this as a partnership between the colleges of medicine and community hospitals for quality health educational programs.

Advances In Medical Education

George E. Miller, M.D., Director of the Center for Educational Research
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Let me focus on the three major issues which face all of us concerned with continuing education, but which you have a particular opportunity to pursue productively through a state-wide grouping of interested persons and organizations. It is in this kind of a cooperative arrangement that we have the greatest hope of transforming the present tired system of continuing education for health professions into something vibrant and vigorous, with a higher probability of influencing the quality of patient care which is the only excuse for programs of continuing education. The principal problems are threefold: (1) the problem of priorities, (2) the translation of priorities into programs and (3) the nature of leadership.

In looking at priorities, one has to ask, "How does an agency, an institution, and an individual decide from all the attractive alternatives?" What is it that a continuing education program will be about?

Those first and second kinds of continuing education programs—the course and the shot-gun—which Dr. Freymann described, are still the dominant forms of continuing education. Priority is determined more by the interest of those who teach than the needs of those who are to learn. Special interest groups or the special interests of teachers are most likely to determine what will be offered. Agencies which have been supported for special purposes, voluntary health agencies for example, design programs around the things that are in their interest and not necessarily the things that have the highest priority in terms of improving patient care. Faculties from our medical schools are more likely to deal with the things that excite and challenge them than with the things that may be at the heart of what practitioners must deal with day by day. Rather than depending upon this *ad hoc*

determination of priorities for continuing education, some system should be introduced into our non-system.

There are many ways to go about it. Let me provide one illustration that was generated by John Williamson when he was a fellow with us. He was trying to develop some rationality for what we do in the name of continuing education. He said that it might seem reasonable to begin by establishing a system of priorities that looked first at the health needs of the target population to which the persons participating in continuing education are addressed. In hospitals, their health needs can be identified in a variety of ways. For example, one might look simply at disease incidence because, other things being equal, the things that are more frequent should get more educational attention than the things which are less frequent. Everytime I say that, I keep remembering when I was a director of medical education in the hospital, setting up grand rounds, week by week for the department of medicine. As I think of what I did with my colleagues, it was often to look around the hospital to see if we could find a patient suffering from a disease that no one had ever seen before, and that no one was likely to see again. If we could find such a patient, that was the ideal subject for our continuing education program. Well, maybe it was. On the other hand, it may not meet this kind of criterion in the development of priorities. Individual disease incidence is not enough. One might also look at the disability to the patients produced by those disorders. Other things being equal, diseases which produce greater disability ought to get more attention than those which produce less, so it is possible to introduce this factor into the determination of priorities.

However, individual disability is no longer

enough, as we look at the broader problems of health service in the community at large. The social disruption that is produced by the disease from which the individual patient suffers should also go into the determination of priorities along with chronicity of disease and cost of disease. These are ways to bring some order into our consideration of what is needed in order to improve patient care through continuing education.

Having identified the needs of the target group, one must also look at the health resources. What body of information is available to meet these needs? What professional skills? What safety? If there is something that falls high on the need scale, but for which we have no resources, it seems pointless to engage in extensive continuing education about it. This is the way in which we can separate the needs for research from the needs for continuing education. It is where the needs are high and the resources low that research ought to be directed. It is not necessarily this way in the determination of what is best for education.

Finally, one ought to look at the performance of those who are delivering health services. If they are already using all the resources that are available to meet identifiable needs, it is futile to engage in further continuing education. We ought to be focusing our attention where needs are high and available resources are not being used. This is the kind of thing that Dr. Freymann was referring to when he spoke about the audit of professional performance. Such an audit should identify deficiencies in performance that might be remedied through education.

Let us turn from the determination of priorities to the translation of priorities in the program. It is important to identify an educational program which has the greatest possibility of influencing the behavior of practitioners which needs changing, and not simply informing them further about what it is they ought to be doing. This means that we need to introduce some of the science of education—not simply the experience of the patient—in

what we should offer as a continuing education program. Determine first educational objectives in terms of behavior, not in terms of informational content. Those objectives may be identified as reflecting a lack of knowledge which has to be corrected if performance is to be improved. They may reflect a lack of personal skill, i.e., translated knowledge into action, or they may reflect an attitudinal set which denies to patients the information which physicians have. In other words, their attitudes are set in such a way that they don't use what they know.

Most continuing education programs focus on knowledge and the delivery of new information to bring practitioners up to date. In the original discussion which led to the legislation creating Regional Medical Programs, the idea was to bring to the bedside the most recent developments from the research laboratories of this country. It was felt this was the way to improve the quality of care of patients suffering from heart disease, stroke, and cancer. That may all be very well, but if one looks at performance deficiencies, it seems clear that the ones that are most significant do not result from a physician's lack of a bit of knowledge, but rather it is his failure to translate into action knowledge that he already has. In fact, those new pieces of information which have the highest probability of impact upon patient care, are so widely disseminated so rapidly, that the likelihood of a physician not having that information is very small indeed. All he has to do is read *Time* and *Reader's Digest* or look at some of the throwaway sheets. Actually the greatest need in continuing education is not that of providing new knowledge, but rather of helping people to use more effectively the knowledge they already have. If this is so, then we have to use different forms of continuing education than we were accustomed to in the past. We must focus on those things that involve learners actively in the pursuit of what it is they need to improve their performance. Our greatest need is that of helping physicians and other health practitioners in educational diagnosis of their own

needs, because the therapy is available in a variety of forms.

Our own program, for example, focuses increasingly upon means of helping individual practitioners not only through the audit Dr. Freymann referred to, but by a variety of other ways, to discover for themselves what it is that they need to learn in order to improve their performance. Professional practitioners are more anxious than those of us who are on faculties to improve their performance and deliver the best possible patient care.

Our task is not to tell them what we know, but to help them discover what they need and translate this into improved patient care. This may be illustrated in the kind of study we did at Rockford. The abstract system is translated into a concrete system which begins with objectives, develops learning experiences that are in keeping with those objectives, and carries out some kind of evaluation to allow us to know whether the objectives have been achieved. If they have, the objectives must be re-examined to see if they are worth achieving. The learning experiences must be reviewed to see whether they were appropriate to achieve the objectives, and if not, they must be altered. In Rockford we helped the staff of the community hospital focus on something that everyone was involved in. Each patient admitted to that hospital got a routine hemoglobin, fasting blood sugar, and a urinalysis. Our study was quite simple. We looked at the patient's record to see what kind of response his physician made to the abnormalities in those routine screening procedures that were reported. We looked for any kind of response, even an order to repeat the test. The response rate was 35 per cent. Thus, 65 per cent of those unexpected abnormalities produced no response at all! Now we made no judgment of this, but simply presented this information to the Education Committee with the implied question; "Do you have a problem?"

They decided they had a problem. They developed a staff meeting at which this datum was presented. People from the medical facul-

ty were available to discuss the implications of failure to follow-up on such screening procedures. One of the most difficult parts of this continuing education exercise was to keep members of the faculty quiet until somebody asked them a question. What they wanted to do was to tell those fellows what they ought to be engaging in rather than taking part in a dialogue. Nonetheless, we succeeded. Ninety per cent of the staff took part, and at the conclusion of this meeting there was uniform agreement among those participants that this had been a superb continuing education program. It focused upon their problems, their performances, and their deficiencies. They enjoyed it, and they resolved to go out and do differently. Well, if we had evaluated this in the usual way, we would have said this is great. A large number took part and they liked it. However, being investigators, we thought it best to look and see whether it changed behavior, so we went back and repeated the study.

Anyone care to predict what happened? Well, there was no change. The Education Committee really didn't know how to deal with these data. They were troubled and said, "Let's wait and see if there is a delayed reaction." Six months later we went back and looked once more. Would you care to predict what we found at this time? We found a significant increase in their performance. It was not ideal, but it was up to 65 per cent. However, six months had passed, and it was necessary to look for an intervening variable. We found one. This study was conducted during the month of July, and on July 1st, that hospital, for the first time in years, had gotten a full intern staff. We had to go back and separate the patients who had been seen by staff physicians alone and those who had been seen by staff and interns. Would you care to make a prediction? All the improvement was among those who had been seen by interns. Well, now it was clear. We had failed to achieve our educational objective, but it was also clear that the learned experience was probably inappropriate.

This was not a problem of knowing. The

physicians knew what they ought to do, and they knew how to do it, but they simply were not doing it. One of our staff suggested this might be a simple perceptual problem where so many normal values came along that when an abnormal appeared, it didn't have sufficient impact to lead to a response. If this were the case, we suggested approaching it as a perceptual problem in learning and not a cognizant or knowing problem. As a result, we simply obliterated the abnormality on the laboratory with a piece of high visibility fluorescent tape that had to be torn off in order to reveal the abnormality. We did that for six weeks, and it gave us a chance to find out that almost everyone looked. After six weeks we went back and did the study once more.

Would you care to predict what we found this time? Well, it was a 100 per cent response rate when we included interns. Quite properly, someone asked "Did they learn anything, or was this simply a stimulus response, which wouldn't occur if the stimulus weren't there? A legitimate question.

The tape was discontinued, and after six months the study was repeated once again. Any predictions? Well, we maintained most of the gain. We have gone back three times since at six months intervals, and results have fallen off slowly, but never back to the point where they were in the first place. I tell you this to illustrate the systematic approach to problems of continuing education which really relate to patient care. It also relates to that final problem which I referred to initially, i.e., the nature of leadership.

If we are to have continuing education programs and some new format, it seems quite

clear to me that we need new kinds of leaders for continuing education. It is not enough to have people who are sincere, devoted, and well qualified in the subject matter of medicine. There is a science of education. It may be an emerging science, but nonetheless it is a science which deserves our attention and our respect. It is a science which we have used very little and have ignored very widely in our educational program planning thus far. The people we need are people who are knowledgeable about the means by which practitioners and health professionals are assisting in diagnosing their own needs. They must also create opportunities which facilitate learning, and help in the continuing assessment of their own performance to determine whether the needs have been met and to identify new ones. Unless we introduce such new professional leadership into our programs of continuing education, it seems unlikely that we will transform the present tired model, even though we may use lots of new technology and lots of new formats. What I am really saying is that we must develop a new attitudinal set about what education is, and a readiness to use people who are experts in education and not in content alone. I use this meeting today as an illustration of how deep our attitudinal set is. Although it is devoted to the consideration of education, I would call to your attention the fact that those of us who appear before you are all qualified in training something other than education. It is time for us to bring in other experts and to use them to recognize their contribution because if we don't, I am afraid we are lost.

Let me end then with a word from that great American philosopher, Pogo, "We have met the enemy and they are us."

Panel Discussion

Dr. Woolsey: It is my opinion that perhaps Dr. Miller underestimated a little bit the lack of need for new knowledge for practitioners, particularly in the rural communities. Dr. Miller supposes that the individuals do have the knowledge, but they aren't acting on that knowledge appropriately. When you realize that about one third of all the practitioners in the nation (except for what they may do entirely by themselves when they are closed) are in no way involved in attempting to acquire additional information, I am not so sure we can feel that they don't need a bit of new knowledge here and there.

Dr. Miller: I would be willing to accept this hypothesis worthy of study rather than as fact that has been demonstrated. The hypothesis is that practicing physicians have a greater need for new knowledge than for improving their skills and translating what they have into behavior. One study was done by a distinguished pediatrician simply looking at a sequence of 100 patients referred to him by practitioners, presumably because they were unable to handle the problems that the patients presented. As he analyzed this, in no instance did he find that it was because the practitioner did not have the knowledge that was required, but rather that he was not doing some simple things he had been well trained to do very long ago.

Dr. Woolsey: You threw in a word that I did not have in there. You said "had more need." I wasn't implying there was more need; I just had implied that there was a need also for new knowledge.

Dr. Miller: Our first need is to determine priority. What is needed most? We must address our attention to these things, and only when the most needed are met do we move into other things.

Dr. Cross: Someone asks about the new tests that are available as self-testing devices. How

effective are these and what may be their place?

Dr. Freymann: Many here took the American College of Physicians "Self-Evaluation Test": 750 questions on exotica—I, for one, found it an absolutely fascinating exercise. It really tested how well you read the annals, and it was a lot of fun. I felt at the end that I might have the satisfaction of having read recent journals, but there was absolutely nothing in that exercise that gave me any evaluation of whether I was even fitted to take care of patients.

Dr. Miller: The self-testing mechanism has the greatest promise of all in leading us into effective continuing education. Self-testing must be a test of those professional skills which are of highest priority in delivering patient care, not in the exotica which pleases the faculty. Let me give you a specific illustration. We are mounting such a program for the Illinois State Medical Society. We will provide an opportunity for physicians to go through a self-testing experience, using a variety of modalities including a model pelvis in which it is possible to insert unknowns. The object is to determine whether they can identify these unknowns. We have a model globe which can have unknown retinal pathology. We'll learn if they are able to identify those things which lead to identification of disease. We'll use heart sounds and clinical simulations to focus on what practitioners do, not simply upon what they know.

Dr. Rawson: How will this fit in with the re-evaluation for re-accreditation?

Dr. Miller: I hope that will be completely separate. If there is anything that will defeat our goal of continuing education it is to insert relicensing as part of this. If we let that happen we will simply *force* people to attend rather than *encourage* them to learn.

Dr. Woolsey: Was your question relative to

recertification rather than to relicensing, or didn't you distinguish between them?

Dr. Rawson: Recertification. I think it would be appropriate for both.

Dr. Morrison: How do you really test the quality of health care delivered to a patient? We can do this as pathologists. We exert the final quality control in a way, but how do you go about it in the day-to-day care of the common cold or in a patient who has some emotional problem? How is that done?

Dr. Freymann: I remember a critical instant technic test which I was conned into taking as an internist. I was directing an obstetrical exercise on how to manage third trimester bleeding. This is an entirely different type of a test. It doesn't test your factual knowledge. You go through the process of managing a patient which is the analysis of information, and then you act on this. On the basis of this action, you have to take another step. You do this by erasing to find out what information you want. For instance, in a physical examination obviously you do a pelvic, so you ask for the pelvic findings. Well, this is a very interesting thing. You get so involved in it that you feel you are managing the case. I quickly found that I was way in over my head. I got to a point where one of the options I could take was to call in a consultant. I picked this little blank, and the answer came out—"The consultant's gone fishing, you're the only doctor in town." At the end of pages of this, at which point my hands were wet and I was sweating, I was down. There was one thing that I could erase. When I did, it said—"You are now censured by the Tissue Committee." Now, that's self-evaluation.

Dr. Miller: We have just sent to the publishers a book that will include 23 such problems for general use in continuing education. In answer to Dr. Morrison's question, I think we must acknowledge that there are immediate, intermediate, and ultimate objectives to see whether or not they are achieved. We then make the assumption that if these are

achieved patient care will be better. In clinical instruction we have spent a lot of time having students work-up patients. As part of that work-up the student puts a stethoscope on the chest, presumably to gain greater skill in the interpretation of what he hears. We make the assumption that this will improve patient care. Well, we can test that assumption, or we can test whether or not the immediate objective is achieved. Last year we tested this by evaluating the students' ability to identify abnormal heart sounds, using a standardized set of recordings. We found that between the second and third year in school there was a sharp improvement in that skill. However, from the third to the fourth, from the fourth to the internship, from the internship to the residency, there was a straight line. There was no perceptible increase in the skill of doing this until one got to be a fellow in cardiology when it went up again sharply. I think these are the ways in which one gets at the component parts of patient care. You try to tease-off elements in essentially pure culture, as a bacteriologist attempts to do in identifying a micro-organism.

Dr. Cross: A question is about the desirability of a program in which the hospital case material is presented and discussed by a medical school representative through a two-day radio communication. Dr. Woolsey, you are a pioneer in this field.

Dr. Woolsey: The two-way radio system, whereby the instructor and the student may interact by exchanging auditory information, is effective. There is a very definite increment in knowledge which is retained to a reasonable degree over a six-month period. But this is just one of the methods. When you think of the ways of doing things, when you think of media, don't just use a medium because it is available to you. This is where most media get into trouble. Television exists. Therefore, we have to use television. You go ahead and use it, and it's a disaster. Determine what you want to do and then try to determine the best method of transferring that knowledge within your capabilities. Design the education relative to making full use of the medi-

um rather than using a medium because it is there.

Dr. Cross: Here is another query—"Who determines the educational needs in a hospital?"

Dr. Freymann: Let me tell you first who is not qualified to tell you what the priorities are—that is the medical school. It is the hospital, more specifically the hospital staff, which should establish the priorities. This is where administration is important. This is what I was referring to when I said, doctors are not clerks. I think one of the reasons the evaluation of priorities has been a failure is because the only way it is possible to do this is to have doctors sit down and go through that incredibly boring process of chart review. The administration has an obligation to provide the clerical backup and the technical expertise. With the application of computers, it is entirely possible to present a medical staff with statistical data on exactly what they are doing. This can be on many other things—incidence of disease, days of disability, days lost from employment, and all these kinds of things. The staff should decide, but the administration should provide the raw data.

Dr. Cross: What about the role of leadership?

Dr. Miller: The place in which attitudes of continuing learning are set is the medical school. If we really believe that we want practitioners to be continuing, independent, and self-reliant learners, then we better provide them with opportunities to become this in medical school and reward them for doing it. Instead, most of our educational programs in medical school seem designed to defeat the achievement of that objective. We make students utterly dependent upon faculty, and then we are surprised when they aren't independent learners after they leave us. We addict them to teaching and wonder why they don't grasp the opportunity to be self-reliant learners. The problem of leadership is not at the continuing education level alone. It is a problem which all of us share throughout the medical educational program, and not only

in the profession of medicine, but in all of the health professions.

Dr. Cross: Here is another question—Do you know where any trained educators are being used in continuing education or education on the postgraduate level?

Dr. Woolsey: In Albany we use consultants from the State University, from the Educational Psychology Department and the Sociology Department. We have a very interesting experiment going on. Eighty practitioners in medicine (internists and general practitioners, selected at random) have been working with us as consultants for two years. They had suggested that, in order to identify whether they had any knowledge deficiencies, we should examine them. We have been examining them before instruction, after instruction, and six months following. In each instance, with 25 subjects, we can identify a need for more knowledge relative to the information they are going to have to have if they are going to apply good care adequately to the practice of medicine.

Dr. Cross: Are there many medical schools that have established Departments of Medical Education, headed by people who are primarily educators?

Dr. Miller: We now have on our staff in the Center for Educational Development 30 professionals, of whom only five have training in the health professions. The rest are derived from the educational profession. They are working in the 22 other offices or divisions of research in medical education. They are at all levels—undergraduate, graduate, and continuing education. Community hospitals are involved in the total school program thus the resources are provided to them. There are very few community hospitals. I am not aware of any which have individual staff members who are qualified primarily in education, excepting York. York Hospital has a staff of this sort and has been a leader in trying to incorporate this.

Dr. Woolsey: This is a good question. I don't

know of any hospital which has done this successfully. You have to realize what the situation is within community hospitals. If the physician practicing in that hospital was so hell-bent for education that he couldn't live without it, he wouldn't be there in the first place. He is out there to practice medicine and to bring service to people. This is a very time-consuming occupation; he works much harder than people realize, and he does a much better job than most people realize. His family affairs impinge upon him, and time is of the essence. The one thing you can put off—and nobody will really know that you are putting it off—is a continuing education effort. It takes real dedication as an individual to be sincerely involved in your own effort without any outside stimulation. In my opinion, only 10 per cent of physicians have such dedication. Your problem then is to get to the physician some way or other, to identify that he has a need. I spoke to this panel of consultants. I had three people, very capable practitioners, come to me individually and say: "You know, before I was involved in this effort, I was absolutely convinced that I was doing what I should be doing to keep myself up on the facts of medicine. I now realize that was not true. I've got to do a better job."

I don't like to decry the things which have been attempted. You need some way to get the individual to recognize that he has a need. One of the easiest ways to do this is to get him in a position where he realizes his lack of knowledge in certain areas. Then it dawns on him that he does have a need. If you can get him into the fold, then maybe you can begin to work him toward the more important and erudite processes of applying what he learns to the actual practice of medicine. However, there are many things you can't control in education. You can never really tell whether a lecture has an effect. You can tell whether it changes practice habits and so forth, but you can't tell what might have been the practice habit a month or two years from now if that individual had not been exposed at this time. Knowledge doesn't stay flat or go up. It goes up and down and stays flat.

Dr. Miller: In Maine, a couple of general practitioners, whose names are Cross and Bjourne, have created for themselves and their community, what I regard as the best continuing education program for individual practitioners. It's all built around the education of the problem-centered record that Dr. Lawrence Week has talked about so much in the last couple of years: the papers in the *New England Journal of Medicine* entitled, "Medical Records that Teach," and the experience of these two practitioners. The way they translated this into their own daily practice made a continuing education program for themselves that was tailored to their needs and not determined by something outside.

Dr. Cross: Dr. Rawson is the chairman of a steering committee which has dreams of providing a high quality of continuing education for all the hospitals in New Jersey. I don't know whether you want to comment further on our ambitions.

Dr. Rawson: Our ambitions are embryonic at present. The RMP has a Council on Continuing Physician Education comprised of representatives from the Academy of Medicine, from The Medical Society of New Jersey and from the two medical schools. Three years ago, after looking and trying to determine what the needs were, the Council asked Dr. Rogers to undertake a study of all the hospitals in the state. He came up with a very good evaluation on size of the hospital, the pattern of the staff, the profile of the staff, and what the educational programs were. This was presented to this Council and recommendations were made. Fortunately, the schools had been discussing the possibility of a Department of Continuing Education in New Jersey under the two schools. This is probably the first thing we had done toward bringing the two schools close together. It has been proposed by the faculties of the two schools that one office for continuing education be created under the two state medical schools with a steering committee. The committee was established with two representatives of The Medical Society of New Jersey, two representatives of the Association of the

New Jersey Hospital Medical Educators, two members of the faculty of the College of Medicine and Dentistry at Rutgers, and two from the faculty at Newark. Also, a member from the Academy of Medicine and one from the New Jersey Association of Osteopathic Physicians and Surgeons were included as observers. We meet regularly and are planning for the development of such a program, but we are still in the planning stage and have a long way to go. This is with the total effort of that group.

Dr. Cross: Here is a query about computerized audits in a hospital.

Dr. Evans: Computers do have a definitive place. Unfortunately, too many people look at computer information gathering systems as audit systems in themselves and they are not. They are simply means of providing you with well categorized data information you can be-

gin to audit. You simply can't go to PAS, HNP, MAP, or any of the computer-based audit systems and read them like a novel. You must go through them with a definitive series of data bits that you want to get out of them. You must ask of them specific questions, so to speak. They are helpful in the business of data gathering, data logging, and data dissemination, but they are not in themselves an audit. I am afraid this is the trip-up many people get into because they have the idea that if they have a MAP they have an audit. This is not true. You have the skeleton of an audit: you have the material and information you can use.

Dr. Morrison: You have the perfect educational tool in your hospitals—namely, the autopsy. It's been my experience that very few physicians ever look in on the autopsy of their own patients. I think the conclusion is obvious.

The Hospital Administrator's View

Edward J. Dailey, Jr., Director
Muhlenberg Hospital, Plainfield

The average hospital in the United States is the 100 to 200 bed community hospital. It is not the magnificent Massachusetts General Hospital or Johns Hopkins. There is a textbook definition of hospitals that Webster gives us: "An institution where the sick or injured are given medical or surgical care."

Community hospitals are usually small, but there are large community hospitals ranging up to 800 beds in urban areas. These hospitals usually retain autonomy of their affairs. Generally they do not have medical school affiliation. At the other end of the spectrum are University hospitals such as Columbia Presbyterian, Massachusetts General, Peter Bent Brigham, and Johns Hopkins. These magnificent teaching hospitals have come into being in the United States in the past 40 years.

Many of our friends in the medical field regard them with great suspicion. There is the third type of hospital, and this perhaps is where my current experience really is; we choose to call it a "community-teaching hospital." This has the best of both worlds. Its objectives are in health care and education; it has complete autonomy to direct its own affairs. The community-teaching hospital has direct contact with a medical school, and its emphasis is in on-going education at all levels and in all disciplines. It is the community-teaching hospital that I will refer to in this paper.

The United States has been engrossed in discussions of medical education since World War II, but there is much glib talk without much tangible progress. The few quiet voices

of medical school deans, hospital directors of medical education, and the people whose lives are devoted to medical education frequently are not heard.

There is a problem in fixing responsibility at the national and state as well as at the community level. Look at your own hospital to see if there is a basic objective for the institution, and then ask yourself the 4 "Rs" about this goal—namely, Responsibility, Role, Right and even Religion. Ask yourself the following questions about education as it relates to your hospital goal: (1) Is it window dressing? (2) Is it a sop to medical fashion? (3) It is a proper and legitimate assumption of basic responsibility in your institution? (4) Are you dedicated and idealistic as regards the blessings of education?

Some hospitals list the medical education function in the lower part of their table of organization and at a low level of activity. They are content to assign someone the task, and then look away as if they have new fields to conquer—which is either a new building, a new science laboratory, or what have you. But is medical education on the table of organization to begin with? There are many hospital tables of organization in New Jersey in which such a department does not appear.

The Muhlenberg Hospital is not typical of hospitals in the United States. It is as different from the other community hospitals I described as it is different from Columbia Presbyterian Hospital. It is a unique organization and it may be an emerging type of community health care institution. Why the difference? First, I must exclude the true community hospital usually in the rural setting, for they may find it difficult to adapt to modern trends in medical education. At this moment, education does not appear to hold a high priority position in their current objectives. We must also exclude the very large teaching hospitals such as Massachusetts General and similar hospitals mentioned earlier. It is not my intent

to discuss hospitals at either end of the spectrum, but to speak of those in the middle.

Fewer than 20 per cent of the hospitals in the United States lie in the 500 bed bracket. This was 10 per cent when Faxon¹ pointed it out at the end of World War II.

The professionals generally misunderstand education and all its ramifications just as much as the general public view video roles of "Dr. Gillespie," or "Dr. Gannon," or some of the other medical programs on television. This misunderstanding is a basic problem in objectives. What is the objective of your hospital? Can you or have you identified the fundamental goal of your organization in the first instance? This difficult task is the exclusive responsibility and duty of the administrator of your hospital. It is the administrator's responsibility constantly to remind people about the basic objective, the primary objective of the hospital. To give another example, ninety odd years ago in our hospital, the objectives were "the care, cure and nurture of the sick and injured"—very beautifully said. The hospital resulted from community action taken after a train wreck in the Plainfield area. Five years ago, the governing board added a resolution identifying those objectives with another—"educational activity at all levels in all pertinent fields, basic to superior health care." Translating this, we are saying the hospital is not only interested in health, but in health education. I suggest that these are the questions: Do you accept a local responsibility for quality health care and thus education? Do you accept this responsibility in a rather provincial and narrow and yet typically American way? Or do you accept the broad responsibility which is the preparation of young men and women in the several disciplines of the health care field? These are basic questions for a Board of Trustees. No one else can assume this responsibility. Medical education in the hospital setting is essential. It is the responsibility of the Governing Board because it is the key to quality health service. If you are going to accept the thesis that medical education is the soft core of institutional life that radiates out into all other areas,

1. Nathaniel W. Faxon, M.D.: *The Hospital in Contemporary Life*, Harvard University Press, 1949.

which builds professionals, attracts professionals, holds them, and continues to improve them—then you must think of education as the heart beat of the hospital.

How to do it? The key is your Board of Trustees;² it is your base, your home plate. Is the trustee willing to shoulder the responsibility and authority of trusteeship and dare to call for something more than the threshold standards of the Joint Commission on Accreditation of Hospitals?² Is this not the responsibility of the trustee in the first instance? This is a social responsibility, a political responsibility, and a community responsibility. Certainly, there is the question of fiscal price, (everything you do has a price tag) and inevitably the trustee must face this realization of standards established beyond the minimums of the Joint Commission moving into the marvelous world of education.

There is a price to pay in many areas, not all of it fiscal. There is an administrative price: an incredible involvement of the administrator's time. It is one thing to have a health care institution, a medical hotel if you will, but when you add all the trappings of education and all the multi-disciplines that abound in the health care field, there is no end to involvement. There are not enough hours in the day. It is "ego" shattering to the administrator. He is used to being the "Big Boss" in his organization and let us face it, we teach that in the graduate schools of hospital administration. We teach the "Junker Chain of Command," utilized by the German general staff, and we insist that all communications in the institution flow up to the administrator and flow down. Suddenly, when you inject a "high powered" medical educator or a chief of staff who can converse with the Board of Trustees about a professional matter, especially about education (of which the administrator may know very little), then I suggest his male "ego" may be badly bruised.

What else do you need in your hospital? You need human resources, you need clinicians, you need educators, you need support from all sorts of people of all types, you need, I sug-

gest, young people. This is not a burden to be borne alone by the senior statesmen. You require young people of stature whose educational qualifications are impeccable, whose integrity is paramount, and whose ideals are obvious. You don't need summer soldiers. You need full-time people, and most of all, good physicians. You need facilities, such as classrooms with proper equipment, settings, and tools. This brings up the question of dollars. It isn't enough to demand dedication and cooperation. There are dollars involved. It is necessary to have full-time clinical chiefs. They must be on the "campus" and they must be on the site. Young people today want to talk to the qualified teachers and they must be present. You need various supporting items, such as an auditorium, classroom, and equipment.

You cannot run an exclusive medical education program. You have to have other people, other types of educators and other bases of support. The program requires intimate contact with a medical school, and a proper organization within the hospital. Leadership appointments must be acceptable to the medical school and to the hospital. This can be done by mutual agreement and consent. It is a question of leadership, too, by the President or the Chairman of your Board of Trustees, the Administrator and the Chief of Staff. These officials must be in complete agreement on their objectives of health and education. They must be dedicated people, and there must be mutual cooperation between them. These leaders must call it as it is. Behind this leadership, you require a strong medical education advisory committee. There is no sense of having qualified chiefs if their dicta are immediately overruled by a medical board that is out of the nineteenth century, or by a medical executive committee that is not in harmony with the objectives of the hospital.

The chiefs that you appoint to leadership need continuity in office at least five years. How can you build a program in one year? If

2. *Standards for Accreditation of Hospital Plus Provisional Interpretations*, JCAH, Chicago, Illinois, 1969.

your chief is appointed annually, and if he makes an unpopular but correct decision he may be voted out of office at the next "popularity contest" of the medical staff. A strong medical executive committee can eliminate the popularity contest for the selection of a departmental chief in your hospital. You are not a teaching institution until you succeed in obtaining the proper person in leadership, and popularity is but a small part of this business. You require a "selling job," because you must have behind you a majority of your staff. Generally you will find the younger physician, the product of the residency programs, has not been brain-washed to the idea that all hospital administrators (or medical administrators and all governing boards) are uncooperative. These young physicians, because of their experience in university hospitals, have a different point of view than their colleagues of the 1920s, and usually hold a high regard for continuing education. You must have the majority of your medical staff in favor of medical education.

The program will vary and develop as you restructure the departmental areas in your medical staff. Frequent meetings are needed; you require less politics and more science which can sometimes be a difficult task. I suggest it can be done—there are hospitals in this state that have done it.

The administrator's task is to remind people about "goals." One of the ways an administrator can do this is by injecting measure-

ments, such as morbidity, mortality, medical audits, and other statistical programs mentioned earlier. We are not, however, trying to make clerks out of the doctors, and I suggest that the people who have succeeded in this effort are our own friends in the federal government.

The job of the administrator is to remind the hospital people of the ends of the institution. When he does that he must be courageous and prepared for the flak that will fly in response. Unfortunately, at times, you will be regarded as a troublemaker. The fact that you may be correct is usually overlooked.

Evaluations of objectives can be measured in the environment of an educational and stimulating organization and in improved patient care. There are maternal death rates, complications, morbidity, mortality, and measures of autopsy performance that demonstrate whether or not you have improved patient care. I suggest that you can also see the uplift of what John Gardner calls "Excellence."

What do hospital administrators receive from all this besides some of the things I suggested. You have total involvement; acceptance as an equal within the professional community; your opinion is sought, solicited, and respected; and you obtain a tremendous feeling of self-satisfaction when you look at the product of the superior health care organization you direct.

The Hospital Trustee's View

John L. Sinn, Board of Trustees
North Shore Hospital, Manhasset, New York

When you examine the problem of continuing education in a community hospital from

3. John W. Garner: *Excellence: Can We Be Equal and Excellent Too?* Harper & Brothers, Publishers, New York, 1961.

a trustee's point of view, it resolves itself to two separate parts. First, how have we accomplished it in our particular hospital and, second, why did we want to accomplish it in the first place!

North Shore Hospital was founded in 1946 by a group of concerned citizens who were seeking to form a small community hospital because there were no facilities in the area to care for even the most emergent medical contingencies. It opened in July, 1953, with 169 beds. It has grown today to 430 beds and is in the middle of a building and expansion program that will increase this to 600 beds within the next three years. It has always been a community-oriented hospital. If you accept the definition that a community hospital is one in which every physician in the area becomes a member of the staff, then, North Shore was never a community hospital. The founding trustees felt a deep responsibility for the caliber of medicine that was to be practiced in the hospital and they insisted on a system of selectivity that would create a staff of fully-trained and thoroughly qualified physicians.

The preamble to the hospital bylaws, which incidentally, is a section of the bylaws which has never been revised, is, I think, a sufficient clue to the ultimate motives of those founding trustees. It says:

"The purpose of the Corporation shall be:

(a) to establish and maintain a hospital for the care of persons suffering from illness or disabilities which require that the patients receive in- or out-patient hospital care.

(b) to carry on any educational activities relating to rendering care to the sick and injured.

(c) to promote and carry on scientific research related to the care of the sick and injured.

(d) to participate in any activity designed and carried on to promote the general health of the community.

It is apparent that from the start, the concept of a continuing educational experience was very much in the minds of the trustees.

There was some violent reaction from some of the doctors in the community and bitter debates ensued during those formative days in various forums in the community between doctors and trustees. The doctors said that all physicians in the area should be admitted to the staff. The trustees were firm in their purpose and it is rather clear, in retrospect, that

right then and there were sown the seeds of what has become a very complete educational program.

From the start, only private and semi-private rooms were built. There were no ward facilities and, therefore, no distinction between patients as to room occupancy. The hospital was structured on the basis of a single quality of care.

Twelve years later, in 1965, the educational ambitions stated in the bylaws were largely unfulfilled. The hospital was committed by that time to a policy of full-time chiefs in all disciplines, but it had not yet been accomplished in most divisions. Although we had a residency rotation with the Cornell Surgical Division, Bellevue Hospital, and a few other accredited residency programs, when we assessed ourselves at that moment and called in outside consultants to do it, it was apparent that we had not as yet gone very far along the educational path.

Here we were, a good community hospital serving a group of expanding and demanding communities with a staff of highly sophisticated private physicians each working solely within his own sphere and using the hospital primarily as a continuation of his office. We were clearly at a cross-roads and we needed educational leadership. We instituted, at that time, negotiations with the Cornell University Medical Center and with New York and Memorial Hospitals regarding the possibility of an affiliation. Cornell at that time was phasing out its program at Bellevue and two distinguished doctors, Dr. Lawrence Scherr in Medicine and Dr. Richard Karl in Surgery, who had been heading programs there, were now available for reassignment. At that moment, we were engaged in a search for full-time chiefs in those two disciplines. They were enthusiastic about our plans for the future of our hospital and our blueprint for its educational program. On the basis of these hopes, they agreed to start at North Shore Hospital. Our hospital's major educational program began with those two men. The key to their success was the fact that they basical-

ly worked within the existing structure at the hospital. They did not attempt to replace that structure.

The programs started then have now been vastly expanded and we have now become affiliated with the Cornell University Medical Center and the Memorial Hospital in New York. From almost the first moment, the changes and improvements came with dramatic suddenness.

Once it became clear that we were offering a real educational opportunity, we found no difficulty in filling our internship and residency programs with bright, top graduates from leading medical schools. Our medical staff of private physicians, although to some degree skeptical at first, responded to it with open minds since they themselves were products of a similar educational system. Therefore, they understood it and appreciated its value. They discovered, for example, that as grand rounds were upgraded, fifty times a year they had an opportunity to attend a conference that they really would have been prepared to travel miles for.

Our educational program demands that they work side by side with bright, young house staff physicians. The private physician is no longer alone, the hospital is no longer just a continuation of his office. We have added as members of his team, active young minds that want to question and learn and know. We have one quality of care for all of our patients. Interns and residents participate in the management of all patients, private and service cases as well. Chart audits have been instituted. Charts are audited on a daily basis while a patient is in the hospital, not long after he has left! All physicians must constantly review and think ahead on all patients. Our private physicians are suddenly in the ideal role of student and teacher, as well. They are the faculty, for each member of the staff is appointed to the faculty of the medical school and helps to provide the education for residents, interns, and now undergraduates. At the same time, since the doctor is no longer isolated, he enjoys the full inter-

change with academic minds, with researchers, with young students learning by the book, and with fulltime peers, as well. In addition, specialty and research groups are available as a back-up for consultations.

You can imagine the amount of soul-searching that goes on on the board of a community hospital when they consider walking down the path toward medical education. I can't tell you how many people came up to me, physicians on our staff, laymen, close friends, well-meaning community leaders, and said, "Why do we have to get involved with things like education and research? What we should really be interested in is good care for our patients and that's what the hospital should really be involved with and leave the teaching to all those big hospitals in New York!"

You listen to enough of that kind of talk and you look at enough budget projections on what educational programs are going to cost, and somebody is going to get up and say, "Who needs this?". That is the moment of truth for any institution. For after prolonged study, conferences with other institutions, advice of consultants, examination of experiences all over the country, we became convinced that the answer to the question, "Who needs it?", was very simple . . . the patient needs it! We became convinced that you cannot have the best in medical care without a program of continuing education, if only for the reason that cases are now more thoroughly reviewed, case histories more studiously taken, charts constantly audited. A patient who has a grave medical illness very quickly comes to appreciate the value and importance of a fine house staff on duty twenty-four hours around the clock, in addition to his private physician.

Our board of trustees, as I think most boards are, has always been dedicated to providing the very best in medical care and the problem of money has always been secondary to that. Therefore, once they arrived at the conclusion that a system of medical education must be provided, they met head-on the prob-

lem of additional finances and, like everything else in hospitals, if it is essential, somehow, somewhere, you find the money for it.

Since we have become an important educational institution, a teaching hospital, if you will, we find that we are attracting more and more bright young physicians to this community, many of them coming up from the ranks of our own residencies. They choose our community because it has an active medical institution on which they can rely.

The North Shore Hospital is living proof,

that a community hospital *can* make the transition to a full-blown teaching institution. It serves as further proof, if more be needed, that teaching and research are an essential part to upgrade the quality of medical care.

I would say to any community hospital that seeks to engage in the same kind of program, if you wish to avoid the severe trauma that can well accompany such profound change, you can do so by working within the existing medical structure. Your medical staff must be a part of your faculty. In doing so, they become your students, as well.

Continuing Education And The Improvement Of Patient Care

Warren Nestler, M.D., Director of Medical Affairs
Overlook Hospital, Summit, New Jersey

In Dr. Nestler's absence this paper was presented by Kendrick Lance, M.D., Director of Medicine at St. Joseph's Hospital, Paterson, New Jersey.

Medical Education and patient care are inseparable. Hence, individuals with the title of Director of Medical Education are involved in patient care, and the educational activities in a community hospital revolve about the patient, not around the physician learner.

Lawrence J. Peter¹ has aptly stated in his book, *The Peter Principle*, "If you don't know where you are going, you will probably end up somewhere else." The long range objective of all of us in the health care field is to deliver quality medical care. The initial step is to define quality care for all patients. Two methods are available for selecting components of patient care which are to be the subject of an educational or study program. The first is the traditional method, with the program built around subject material. Specific diagnosis or patho-physiological states, at times with a patient serving as an example, provide the curriculum for learning activity. How is the subject material usually selected? The stimulus may originate from one of the

staff physicians: "I have a case" (usually a rare disorder which provides more entertainment than education); "how about a talk on . . .", or, "I know a good speaker." On the other hand, the director of medical education or the departmental education program planner is not much better. He has a schedule to fill; and besides, his reputation will be enhanced if he can obtain name speakers or organize courses or symposia with posters and mailed brochures. This traditional method of subject selection might better be termed "opportunistic."

I am not implying that this method is of no value, only that its focus is on the *teacher* and the *learner* rather than the *patient*. An "opportunist" director of medical education, who can poke his nose into all aspects of all patients' care, is in a position to identify patient care problems and then design educational programs centered about the problem. The duties and responsibilities of the DME therefore should include provisions for his involvement, by some means, in patient care.

1. Peter, Lawrence J.: *The Peter Principle*. New York, 1969, Morrow.

The second method of selection of a subject for an educational or study program is by the *audit system*. The medical audit serves two interrelated functions, evaluation and education. A medical audit is the evaluation of the quality of medical care as reflected in the medical record. To perform the evaluative function, the reviewer is required to analyze the care rendered to patients. Once we start critically examining what we are doing, asking the question "Is what we are doing meaningful?" we are already knee deep in an educational process. An educator could be considered a success if he confined his activities to just asking the right questions. In addition, the medical audit is an educational process by virtue of sharing a common goal—the improvement in the quality of patient care. The medical audit is *not*—and this should be stressed—a punitive or policing system. It does not identify individuals, but describes patterns of practice of the group.

In this audit system, the *selection* of the patient-care problem is a function of the departmental audit committee. The problems selected are thus relevant to the largest number in the group, relating to the daily activities in the care of their patients. The medical department audit committee might select stroke, congestive heart failure, or myocardial infarction to study; the orthopedic surgeons, hip fractures.

Brown² has structured a selection process based on the documented needs of *patients*, determined by studying one's own hospital data. The needs, or patient care deficit, provide the content for a continuing medical education program. This selective system is further refined so that priority is given to those diseases causing *patients* the greatest amount of preventable disability. Physician learning is directly related to patient care, with a specific objective for decreasing the deficit patient care deficit.

The audit committee, having selected a cate-

2. Brown, Clement J. Medical Staff Conference, University of Colorado School of Medicine, September 30, 1968.

gory of patients to study, proceeds to develop standards of performance which will serve as the objective criteria against which the provider group will be measured. The standards of care can also serve as guidelines for the development of a patient-care system, or as a framework for discussion of the selected topic at an educational conference.

Members of the committee will ask the question—what should we be doing in order to provide quality care? The answers are derived from patterns of care which *they* have observed in actual practice, and which is assumed to constitute good practice. The source of criteria, therefore, is one's own staff, reinforced by a review of the pertinent scientific literature. Visiting experts can be consulted as needed, particularly when controversial topics are the issue.

The developed indices of elements of performance are indices of quality, the "what" of medical care. Concentration is on the basic components of decision making, rather than the decision *per se*. Thus, emphasis is placed on the skill in gathering clinical information, particularly the required elements of a comprehensive medical history; since the latter is the most crucial factor in establishing a correct diagnosis and hence providing the correct therapy. Additional specific diagnostic and therapeutic procedures complete the performance index. Omitted from the elements of performance are those elements pertaining to the clinical judgment of the attending physician, which cannot be measured with precise tools. Likewise, controversial procedures are omitted.

For the committee, the organization of standards is an educational process in itself. Again, the involved physician is critically analyzing his management of his own patients—"Is what I am doing meaningful?"—a superb method of self-education.

Next let us consider ways of achieving the goal. Basically this step consists of the acquisition and dissemination of knowledge, with the target group the *providers* of medical

care. Any patient can readily define the provider group—the multiple disciplines comprising the physician, nurse, nurse specialist, inhalation therapist, etc.—a *pluralistic management structure* of patient care. The physician, the leader of the team, performs in most situations as if he were a one-man team, with the attitude that nurses and paramedical personnel are working for him, rather than for the patient.

All the providers of patient care (physicians, nurses, and relevant paramedical personnel) actively participate in formulating the policies and plans in the hospital, and are involved in the continued operation of the patient-care information-decision system. The successful performance of the coronary care unit is a prime example of the value of the team approach. At Overlook Hospital, all personnel in the CCU have been implicated since the initial planning stage in 1964, with involvement continuing in the operation and educational activities. This organized clinical unit is composed of equal numbers of physicians and nurses; and an inhalation therapist. To provide nurses with more extensive involvement in the professional delivery of patient-care services, the AMA House of Delegates, in June 1970, endorsed a statement calling for participation by registered nurses on committees of the medical staff which focus on patient care.

The driving force to meld the disparate disciplines involved in the care of any category of patient into a smoothly functioning team is education—the coordinated, cooperative, common goal-oriented programs of medical education and in-service education. In keeping with this concept, some hospitals have a single department of hospital education, encompassing all of the educational activities of the hospital. Although we have separate departments of medical education and in-service education, there is a close liaison between the two. Nurses are not only invited to attend all educational conferences and courses; they are urged to participate in discussions (they do participate, at times to the embarrassment of the physicians!). A hospital-wide Cardio-

Pulmonary Resuscitation educational program was designed and is operated jointly, by the departments of In-Service Education and Medical Education. Physician learners may find that their instructor or examiner is a nurse.

The qualified and knowledgeable nurse and even a technician, can with tact and confidence, function as a physician educator, changing the behavior (for the better) of the physician.

Traditional educational activities are essentially information transfer, and while they are not the core of the educational program, they are valuable, especially if they are in response to a defined area of need. An example is the presentation of the criteria developed by the Audit Committee at a scheduled departmental educational conference. Involvement by members of the department (the providers) is encouraged with full discussion, and hopefully controversy, with the opportunity of the members to alter the standards. The final form is approved by vote, and thus they become accepted standards of care—sort of quasi hospital policy. The next step is the widespread display of this information (standards) in the report of departmental minutes and special bulletins. Copies of the standards are available within the patient care areas for convenient retrieval by the physician or nurse.

The DME, utilizing managerial modalities, can enhance the value of these courses, conferences or seminars by translating content into a format which describes the *process* for the delivery of care, tailored to his own hospital. This process-oriented report can become the guidelines for the development of a patient care system, or as a performance index for use by the Audit Committee, a means of closing the gap between the knowledge level and the practice level.

The role of the DME is to satisfy the first prerequisite for the provision of quality medical care by organizing an educational system designed to ensure the providers' ability to

obtain relevant up-to-date knowledge or to reinforce retention of old information. But this is only half a loaf and by itself is of no value to the patient. Knowledge and performance are not necessarily related. The necessary information for quality care may be provided, it may be acquired by members of the patient care team; but this is no assurance that the best performance will occur. If no change in *performance* of the learner occurs, we have not even satisfied the objective of any educational activity; likewise the DME has failed in his role as a change agent.

There exists in any institutional structure a barrier to satisfying the second prerequisite for the provision of quality medical care: the provider's ability to use this knowledge unerringly, rapidly, appropriately and reliably in the daily practice of medicine. The complexities of patient care, together with the morass of the institutional structure, has spawned, in many instances, medico-administrative barriers to the *delivery* of quality care by the knowledgeable provider group. The "what" of patient care is not translated into *action*. There exists a need for a person-in-charge, responsible for the *implementation* of the system, a manager who will coordinate the diverse elements of the patient care team. The DME could act in this capacity, or if the situation warrants, a second physician would have "administrative" responsibilities. Such individuals have varying titles: Director of Professional Services, Medical Director, Medical or Patient Care Coordinator, or Chief of Department. Essentially, the person in charge at this functional level of patient care might better be termed the patients' *ombudsman*.

An illustrative example of some of the concepts discussed is a course recently held at Overlook Hospital, titled "Systems for the Management of Acutely Ill Patients." The course was in response to requests from one of the four members of the Emergency Room panel of physicians, and a general practition-

er. It was designed by the DME in conjunction with both the emergency room physician panel and Supervisor of Nurses. The most common clinical problems encountered in the ER area over a one-month period, provided the rationale for the selection of the twelve sessions. Utilizing the instructional method of an authoritative lecturer from the medical staff as a focus, the DME moderator generated discussion by the participants. Learners comprised personnel from the ER, both physicians and nurses, in addition to physicians in private practice. Following each session the DME translated the content into a process-designed format, which has provided a *basis for action*.

The DME involved in the course previously described suggested during the final session that an assessment of the care delivered to patients in the emergency room be performed by the Audit Committee. Utilizing the process type notes from the course as a framework, members of the Audit Committee (the criterion group) are developing standards of performance, against which the quality of care delivered can be compared. The source of information concerning the actual performance is the medical record (in this instance the emergency room record) an objective tool for the evaluation of care rendered in the hospital.

Effectiveness of the patient care system is measured in terms of *changes in patient care*, rather than the more limited evaluation of the learner-provider group. Thus the medical audit, structured along these lines, provides a means of assessing all components of the hospital education-information-patient care system. In addition, the medical audit is so designed that it can serve as a model for quality control and peer review, which is the current concern of health care planners and fiscal agents. Results of all our medical audits are reviewed by the hospital board of trustees, who have the legal and moral responsibility for the quality of care.

The Third Party Payer And Physician Education

Joseph P. Donnelly, M.D., President
Medical-Surgical Plan of New Jersey, Newark

In a section of Dr. Nestler's paper, he commented that some physicians think that nurses and technicians are working for them, and are not part of the team. It is true that there are a few who feel that way in every hospital. However, I realized the team effort early in life. On the third day of my internship at Duke, I was scrubbed as the fourth man on the team with Dr. Darrell Hart who was the Chief of Surgery, and Dr. Robert Ross who was the gynecology professor. It was a consultation; we were all scrubbed and ready to go. At this moment a little nurse, whom I had never seen before, notified Dr. Hart that he had inadvertently touched his gown. He thanked her and went out to change it. That incident impressed me that the nurse is an important part of that team. She should be listened to as well as directed. I believe that medicine has in the past been practiced as a team, with the exception of a few "all-stars" that are present in some hospitals, and that medicine will be practiced as a team in the future.

For the benefit of some of our younger physicians, who think that, like the discovery of the electric light bulb, continuing education is somewhat new, I can only tell you that one of the fortunate things in my life was when I started practice in 1936, in the Margaret Hague Hospital in Jersey City. We had 85 per cent clinic patients and 15 per cent private patients, and at that time we did not have a Director of Medical Education as such, but we did have Dr. Sam Cosgrove and Dr. James Norton. We had conferences constantly at our hospital and every Monday afternoon we went to Cornell in New York for their conference. A director of medical education has a great deal to add to continuing education and there is much work involved in organizing and presenting educational programs. The most important element necessary for success in such programs is the incentive

and motivation of the medical staff. The director of medical education can, of course, stimulate the interest of the staff, but the staff must have inherent interest to start with.

I'm here today to tell you about the third party payer and how he would contribute to medical education in the community hospital. I am here as President of Blue Shield. Blue Shield—the Medical Surgical Plan—and Part "A" of Medicare are not directly involved in the payment or support of continuing graduate education. The purpose of Blue Shield and Part "B" of Medicare and other Medical-Surgical insurances is simply to pay the physician for services he personally rendered to his patient. Now the physician should use the money, and he usually does, from the payments he gets to further his own medical education or for societies, literature or conventions, and so on. This is about the only way Blue Shield is involved in this type of subsidy, except in a few cases where the Director of Medical Education sees patients whom he attends and renders services, but this is very indirect.

Blue Cross and Part "A" of Medicare pay the hospitals for services rendered patients in the form of medical care. It has been generally accepted that those expenses of hospitals which improve the quality of patient care are compensable by the carriers. For that reason the salaries of the doctors, as directors of medical education and their assistants, are approved items in the budget when they begin to calculate the total budget cost, and the hospital *per diem*, on which they are recompensed. All of these items in the budget, which are approved by the administrators and the hospital board of trustees, and which are used to improve the continuing education of the staff, as well as the resident staff, are all compensable under the carrier. The cost of

setting up meetings of the hospital, including guest lecturers, securing motion pictures, literary facilities and convention expenses for the Director of Medical Education, and in some cases, even those of their Chiefs of Staff may be included in the hospital budget from which the *per diem* costs are arrived at and which are paid by the third party carrier. In other words, if these expenses are *directly connected* with a program of continuing education for the hospital staff, then the third party carriers will compensate the hospital. It is realized by the carriers that if you increase the quality of the education of the medical staff, you increase the quality of medical care which is rendered by that staff.

However, in some areas these expense charges would be questioned. One would be the cost of private research carried on by a member of the hospital staff which is not directly connected to the care of the patients in the particular hospital. On the other hand, we all know that members of the clinical staff involved in clinical research, frequently make use of hospital stenographers, record room, librarians, and para-medical personnel who assist them in writing and typing their clinical papers. These services are readily absorbed in hospital budgets, and with rare exceptions are compensable by third party carriers. Therefore, I would say, the third party carriers are willing to pay for the continuing education of hospital staffs, because it adds to the quality of medical care.

Until now I have been talking about graduate medical education which includes the house staff and the regular staff. I do not believe that Blue Cross subscribers should be asked to subsidize undergraduate education, even though the medical student may be a part of the hospital team which is rendering medical care to the subscriber. I do not believe (and I am sure you do not believe) that the subscriber or the patient should pay the medical student because the student's educa-

tion is being advanced by studying the patient, any more than the artist's model should pay part of the art student's tuition because the art student is painting the model. As private voluntary hospitals become affiliated with medical schools, and their patients are used for undergraduate teaching, there is a tendency to have the private hospital pay part of the cost of full-time faculty who are supposedly engaged in full-time teaching and are not directly involved in patient care. Private medical schools and public medical schools have a responsibility to the whole population and undergraduate education should not be subsidized by third party subscribers, or third party beneficiaries or by sick patients, without insurance.

The spiraling cost of hospital care and the per diems which have risen in a decade from \$40 to \$110 or more are being carefully scrutinized by third party carriers and their subscribers. They cannot be asked to pay for undergraduate medical education, vaccination programs, school health programs, and all the other public health projects that affect the health of the community. This is a community and government responsibility.

I would just like to read to you, in passing, a section of the Wharton report which is a report of the Public Defender at the last Blue Cross rate hearing. This was turned over to the Banking Commissioner. He is talking about expenses not allowable: "There are other expenses which are of a community nature and should be borne by general taxation, rather than through patient charges or Blue Cross reimbursements. Included in this sphere are the cost of education and training of doctors. At the present time Blue Cross shares in these costs by having such items included as part of their reimbursement formula. The training is for the benefit of the entire community and should be borne by the community at large."

Cost of Medical Education In The Community Hospital

Robert L. Evans, M.D., Associate Dean
Medical School of the University of Maryland, Baltimore

Medical Education in a community hospital isn't a program. It isn't even a group of people. It is an environment—one in which you live and breathe and care for people. Let me start with the basis of the pyramid of care and education.

Basically, I visualize a pyramid, which starts with a *few patients* and a *couple of doctors* who have the ability to learn and interact; a *record system* which allows them to use the patients as a text book; *the desire* and *the commitment of the assignment of a task*; to take a look at the quality of patient care, which comes before, and is an integral part of any educational endeavor.

The first steps in building this pyramid are the exercises we use for quality of care. They logically belong in the cost of what we are doing. We add to this the critical mass from before. You can't change the leadership of a \$13 million corporation, change all of its chairmen, all of its committee heads, all of its officers a little faster than the procreation of man, and expect that their ideas will have any consistency. Attendance requirements and chart disciplines are long talks in their own. You must have someone to educate, assuming your programs are good, and you've got to have the textbooks to work with. If you do these, you supply the pertinence which is necessary to involve physicians, nurses, any allied health personnel you are talking about.

Now what are the *exercises* we are talking about which are part of our cost: (1) Departmental meetings, (2) Audits and Consecutive Case Conferences, (3) Morbidity and Mortality, (4) Tissue Committee, and (5) The Executive Committee, which is the group that keeps all of this going. This is where the peer pressure and the peer responsibility are exerted within a medical staff to produce the envi-

ronment we are talking about. So all of these things, which we have always looked at conveniently and pleasantly as exercises for interns and residents, are really exercises for continuing education, and more than that, are exercises for quality of care. This is the first step upon which you build everything else.

Add to this environment a few visiting experts who come in with new ideas, newer methods of doing things, different ways of approaching the problem of continuing education, and you have in this two-step pyramid, all by itself, a competent system of continuing education, fully founded on quality of care where it has to be founded. It has pertinence, it has meaning in the system and meaning to the patient.

Should you want to complicate this a bit further, as in a larger hospital, take an additional step. Once you have Quality of Care and Visiting Experts you can add graduate education. Because once you do the first two things you have to add a little larger institution, a few chiefs or teachers for bedside teaching rounds, and special teaching meetings of one type or another. Then you already have competent graduate education. What you do have provides the basic grist for the mill of intern and resident teaching and only these things need be added.

If you want to go a step further and add students now, you add them at the top. Everything that you do for continuing education, everything that you have done for graduate education all adds to what you need to do for student education. Thus, these costs are almost impossible to separate clearly—they overlap. We will not try to separate them totally as we go along. You may have some costs for compensating teachers, specifically to teach students, for some of the rea-

sons Dr. Donnelly outlined above, and these we will separate.

Finally you put on the pyramid a capstone—for someone who asks Why? How? When? and you have Research. You have the kind of research that our hospitals should be doing. That is, research in patient care, in the delivery of health care to a population that we serve. If it is incidentally valuable, in the state, in the nation, that is fine. It should be primarily aimed at improving the care of the people with whom we work. All of these things, then, feedback in; the research tells you what you are doing right, what you are doing wrong. It measures or it directs you toward the objectives that Dr. Miller spoke about. Perhaps it gives you some idea how best to reach those objectives. Finally, it serves you as an evaluative mechanism to tell you whether you have reached them or not. Every level feeds back into another.

What about paying for all this? Visualize a line with research and medical students above, and house staff and visiting experts below. Full-time chiefs and classroom expenses might straddle this line. Everything below this line is hospital-patient responsibility. Everything above it is government, endowment, medical school, and industry responsibility. Everything below the line is a justifiable cost of taking care of patients. It is the reasonable cost of the day-to-day operation of a hospital. This includes those things which you do for the quality of care. Quality of care studies are the quality controls in an industry. As Dr. Angelides so aptly put it, "The product is the maximum number of health years for the populace." These are the quality controls that measure what you are doing for your populace. These are the people who add new spice and new ideas to the system. These are the people who provide an otherwise impossible service, at least in our present economy, of 24-hour emergency care, of additions to the community of new, young, well-screened physicians who have had an opportunity to select what they wish to do, and who join willingly in what you are doing—thus assuring the community of a continuing

stream of competent physicians. These are a hospital-patient responsibility.

Once you get above the line you enter some areas where there is a real question of expense. Students may later establish their practice anywhere. They are not going to stay necessarily in the unit or in the hospital where they have been taught. Therefore, they probably should be an expense of the university and through the university, of our society, whether federal, state or local, and in terms of support from endowments, gifts, and so on.

Research is not quite so clearly broken up. For instance, the cost of maintaining the quality of care programs, and the research that goes into bettering them, seems to me to be clearly an expense justifiable in the average daily operating cost of the hospital. If you talk about the fractionation of skin squalene on the other hand and really basic medical and biologic research, no matter what its basic purpose, it is really being conducted to improve the vast fund of medical knowledge. It affects our society as a whole, and it should be carried by our society as a whole, by government, by industry, by endowment and so forth. So there is some clear cut separation. There are also some clear cut amalgamations, easily identifiable. For instance, expenses for full-time chiefs, or full-time educators of one type or another, for classrooms, for building support and some of the expenses for house and staff are fed into student expense. Who can say how much time a full-time educator spends in the continuing education of his staff, as opposed to the education of his interns and residents, as opposed to the education of the students who may be present in the environment? It is impossible to state. The same thing holds true here. How much does the visiting expert brought in for continuing education, primarily, contribute to the teaching of the house staff, how much does he contribute to the teaching of the students? There are tremendous amounts of money which overlap.

These areas are clearly definable. Depending

on the complexity of the program, this should cost between a dollar and a half and somewhere around four dollars per patient day. I had hoped to be able to give you precisely what our present costs are today. The last accurate study done recently showed that the cost is \$4.33 per patient day. About eighteen months ago, our costs were \$3.79 per patient day. This handles my salary, the salary of the house staff, and at our hospital, the salaries of fifteen full-time individuals, other than anesthesiologists, radiologists, pathologists and emergency room physicians. It covers the cost of the programs at the hospital.

What does this do for you? In our community we have added an average of 10 physicians a year. We have gone from 76 physicians per 100,000 population to 110 per 100,000 and we are continuing to increase the number of physicians in that ratio yearly. These are specially selected people whom we have an opportunity to screen. Physicians educated elsewhere are attracted because of the environment which is present. They know they can practice good medicine, they know that they can stay abreast of it. These figures testify to the value of this type of exercise to any hospital.

What about income? There is hidden income in a great deal of this. There are special needs that you have in a community. We have a classic example of a well-trained internist specializing in infectious disease, a most capable individual. We found that we needed someone in our laboratory with a master's degree or with a doctorate in microbiology to handle our infectious disease program and direct our laboratory people. What we did was use the salary support that we would have used for a master's or a Ph.D. candidate to bring this internist to our hospital, let him supervise the microbiology laboratory and have available to us in the community the services of an extremely competent clinician in infectious diseases who wanted to limit his practice to infectious diseases alone. He could not have done this and existed in the population of our community doing nothing but infectious diseases. There are examples of

this in other clinical areas as well, for example, endocrinology, cardiology, chest diseases and so forth. Thus, it isn't pure layout for education alone. There is layout and income to the hospital through increased use of diagnostic facilities and tests. There is recompense in terms of administrative salaries paid to these individuals for operating special units of various types. There are all sorts of other hidden income. For instance, if you achieve the status of medical college affiliation, IBM offers a sizable reduction in the cost of virtually all of its equipment. As I remember it, it is about 20 per cent on office equipment and as high as 50 per cent on computer equipment to educational institutions. This is true of many other major office suppliers. It is true in many areas of telephone companies and other public service and utility companies. So that there are real sources of hidden income.

Mutual educational programs are usually run with various companies. Our hospital, for instance, has a program in which hospital sales representatives of one of the major pharmaceutical companies live with our house staff and our attending staff for two weeks (under an agreement that they do not sell any drugs). They observe some of the travails and stresses upon the physician in the hospital atmosphere. In this manner, they have a better understanding of whom they are talking to, and what his problems are. The impact of this has been fantastic, not only for the company but for us as well. They pay an adequate tuition for training these people which is more than enough to cover the cost for our visiting expert programs, the specialty people invited in for consultation, for a retreat for our department of education once a year, and so on.

This is all without mentioning grants, which are no longer a dependable source of income. They are still available in some areas, however.

If you are concerned with the cost to your hospital, measure it against the cost, both monetary and in human suffering, of not having it.

The Staff Physician's View

Arthur Bernstein, M.D.
Maplewood, New Jersey

On this matter of continuing education, I shall try to tell you what the medical staff wants. This is a difficult subject, for no one truly knows what the staff wants, let alone me. If anyone does know, I would like to hear from him. For there are no two people who learn by the same method, who learn from the same thing, or have the ability to absorb in the same way. Until we find out all about these methodologies we will not be getting anywhere.

Let me quote from Sir Andrew McPhail (1933): "I am well aware that in these days, when a student must be converted into a physiologist, a physicist, a chemist, a biologist, a pharmacologist, and an electrician (and that is certainly true), there is no time to make a physician of him. That confirmation can only come after he has gone out into the world of sickness and suffering, unless indeed his mind is bemused, his instincts so dulled, his sympathies so blunted by the long process of education in those sciences, that he is forever excluded from the art of medicine, which was to Hippocrates, the art of all arts. In that case he is destined for the laboratory, the professor's chair (with apologies to the professors) or the consultant's office. What would have happened to Sydenham had he been put through this machinery as a problem in infinity, which no human intelligence is competent to solve."

This sets the keynote of what we are trying to say in this presentation. What is it that we are faced with? One of the things we heard today, is a tremendous divergence of opinion. This is good. Walter Lippmann, in a column some years ago, said: "When we all think alike, no one thinks very much." I believe many people are beginning to think. The presentation we heard today is a very thoughtful one, and that is very exciting for

it puts things in the true perspective.

Permit me to give you the perspective of the staff man, which is best expressed by this poem of Dr. Chrechefsky of the Wistauer Institute:

Cholesterol is poisonous, so never eat it.
Sugar, too, may murder you, there is no way to beat it.
Fatty food may do you in, be certain to avoid it.
Some foods were rich in vitamins, but processing destroyed it.
So let your life be ordered by each documented fact,
And die of malnutrition, with your arteries intact.

This is the dilemma of the staff physician and what he is faced with each day. What is he to tell his patients? This is one of his problems in education.

We must begin this educational process in uncertainty, which is what we all live in. The staff man lives in the world of uncertainty, no facts, all "maybe." This is what is lost in the educational process very often. Our students think that there *are* facts. That these are very important and at times only one fact, which makes for a problem. Dr. Whitehorn in *Prospectus in Biology* some years ago wrote as follows: "The educational programs, generally experienced by the physicians of the past few generations, have without intending to, inculcated an expectation of certainty of knowledge and a phobic aversion or an intolerance of uncertainty. The worst offenders have been teachers of science. This has been an error. A stultifying error to inculcate the expectation of certainty of knowledge is a serious betrayal of the essence of scientific movement, which has been the great bold adventure of mankind in recent centuries."

Expressed in terms of punctuation marks, it is not right to symbolize science by a period, which closes a statement with an appearance of utter finality. Science is better symbolized

by the question mark, signaling a doubt, and a further look. It is the questioning, not the finality, which best represents science as a powerful instrument of progress in our profession and in general. But how few of our medical students were fortunate enough to be introduced to science is a guess. (They had to obtain marks, if you will remember.) How many were forced by dogmatic teachers to accept science as a set of facts. The worst offenders, and thus inculcating the illusionary expectation of certainty of knowledge, have been the teachers of science in high school and in medical school.

This is about to change, I believe, and it is about time—but it has not changed yet. Those of our generation are in the situation just described. This is the problem in graduate education. There is another problem, and I was surprised that none of the previous speakers today mentioned it. The problem is about education *per se*. We are all the victims of pedagogy, the teaching of children. But we are no longer children. Recently, it was my pleasure to spend a few days with Dr. Knowles, a professor of education in Connecticut. He talks about androgogy, the teaching of the adult, or adult learning. This is a completely different thing. The child moves from dependency to self-knowledge, he said. The adult must not be put in a dependent relationship with the teacher. He must make his own decisions and have self-directed learning. The adult must have a completely different approach than the child. The adult has an experience which a child has not. This experience becomes part of his identity, and he must not devalue his experience. He must use this experience. This is most important, for from time to time, when talking to my residents, I may relate to a case seen many years ago which resembles the case being discussed. Their response usually is that they do not need my anecdotal stories, they want the facts, they want statistics.

What makes up statistics? Facts, from anecdotal stories. If you add enough anecdotes together to make one hundred, then it becomes a statistic. This is the thing we lose

sight of. That in the teaching of an adult, we no longer have a clean slate, we have a mind that has been fixed and been trained. We must use it, if we are to train and teach the adult. He has a completely different orientation, he wants to learn things that are of use to him. He is problem oriented rather than subject oriented. He has a readiness to learn, because he knows he must learn. A child learns whatever he is told to learn, thus an adult will best learn what he thinks is relevant. This is the answer to the education of the graduate physician. He must be taught what is relevant. If it isn't relevant, he will not be interested. Dr. Knowles points out that there must be an adult climate, there must be the involvement of the learner in diagnosing his own needs and in planning to use the resources that are available.

When you begin to teach the graduate physician, you must use androgogy and not pedagogy in your teaching. The graduate physician and the physician in practice learns in many ways. How does he learn? Consider the many problems he is faced with daily, and the various ways of learning, some of which are as follows: there are advertisements in journals, detail men visit the physician, you may meet another physician in the corridor who asks whether you read an article in the journal about a topic, formal consultations teach you something, you read various types of journals and abstracts, you attend meetings and courses, clinical conferences at the hospital, audit committee meetings, and ever so many activities and sources, even the *Reader's Digest*. From all of these things you learn and you also learn from your patients every day.

Thus the sources of learning are numerous; which one, however, works best for the physician? The method that is more successful with most physicians is the well-prepared clinical conference in the physician's own hospital. In this manner, the experience of the physician is used to help him meet a problem that he meets everyday. Dr. Miller today, was telling us that when he was a Director of Medical Education in his hospital

some years ago, he would select the most bizarre cases to present, and the practical value of such presentations is questionable.

Take one example of a well-planned clinical conference of interest, on a subject that physicians see everyday: a clinical conference on pulmonary embolus, presented recently at our hospital. The program was well thought out and on a subject which is an everyday problem. It takes advantage of past experience, because it brings in the physician. You stimulate him by reinforcement, and in doing this you call in everyone who may be interested and involved. The case is well documented and summarized, and each participant was asked not only to present his own area of experience but to review the literature, and present a broad presentation on the subject and not a stereotyped article. The conference involved itself not with one case presentation, but with a discussion of many cases of pulmonary embolus. In this manner, the subject was thoroughly discussed.

This is a well thought out clinical conference which will be of some benefit, because it presents a problem to the physician. For over 35 years, I have been attending these conferences at my hospital. I can tell when we have a good conference by the size of the voluntary attendance. It must be a service conference, it cannot be a whole-hospital conference, because the day of the whole-hospital conference is over, with the possible exception of the small hospital where all men are interested in general medicine. In the larger hospitals specialty meetings must be held.

When you have a topic that touches the man in his everyday practice, something that will help him treat his patients, he comes to the conference, is interested and remains for the entire conference. The conference on pulmonary embolus I mentioned, was a four-hour conference that lasted two days. It had just as large a crowd on the second day as it did the first. It was conveniently held at the hospital, where the physician had to be to see his patients and where he was available if needed. He was notified in advance of the confer-

ence and could make suitable arrangements to attend, and most important, he got something out of it.

The plan in these conferences is to use your own staff men. They must review the literature, and because they are appearing before their colleagues (which incidentally is a form of peer review) they cannot afford not to be thorough in their presentation. At times, it may be well to invite someone from the medical school or from another hospital who may be more knowledgeable on the subject to be discussed, but it should not be done to the extent of excluding your own people. The one who learns the most is the teacher. This is the value of a house staff. It is reinforcement. Anything you learn you lose, if you don't use it. How do you use it? By teaching and by using it in everyday practice. If you don't do it, you may forget it in a short period of time. Therefore, it must be done by reinforcement, utilization of your own staff, by systematically preparing subjects that will give you a good review.

Dr. Griffith, in an article some years ago, noted that in a community hospital, physician training must continue. The responsibility lies with the chiefs of the specialty services, with the Director of Medical Education. But the entire staff must be involved for a successful program.

Let me read something that appeared in the *Journal of the American Medical Association* in July, 1970. It is controversial and may raise the hair on the back of some necks. It is an article by Dr. Picciano, and I shall read a small section of it. I may add that the editorial in that issue criticized the article. I quote:

"I contend, that one of the most serious mistakes of Medical Education Administrators has been the recent trend toward the use of full-time faculty in clinical areas and the spurning of practicing physicians in the intimate teaching of medical students. It is obvious to me now that one of the major problems is that faculties, in general, have little sensitivity to medicine as it is practiced in the 'real world'. I believe it is high time that there should be increasing use of practicing physicians in the active teaching of medical students in clinical medicine. By this, I do not mean a token gesture, but real live practitioners giving up a fair piece of their time to teaching of medical stu-

dents. The exposure of medical students to good practitioners will have a most salubrious effect on medical education. Practicing physicians, having been carefully selected by their academic colleagues, who receive the call, as it were, to contribute a portion of their time to the teaching of young physicians, have the moral obligation in the name of the ancient and revered profession to respond to this call."

This is important, not so much in that they teach medical students, but mostly for the fact that you cannot learn if you don't teach. You can't teach unless you have that kind of an atmosphere. Whether you teach your own

colleagues, or medical students, or nurses or yourself, you will never remember anything unless you continue to use, reinforce, and again reinforce by repeating the process. In this manner you improve staff knowledge by the training of your colleagues and peers as well as your house staff—you truly learn something. Let me leave you with a little philosophy from the elder Huxley. He said, "If a little knowledge is dangerous, where is the man who has so much as to be out of danger?"

Cancer Crusade Urged

The National Advisory Cancer Council has urged increasing educational efforts to warn the public against smoking. Based on an intensive, four-month study, the report submitted to a United States Senate Committee, estimated that 50 million Americans now alive would develop malignancies and that 34 million of them will die unless steps are taken swiftly.

The consultants recommended a sweeping program keyed to consolidation of all existing cancer research projects into a national cancer authority directly responsible to the President. "The Committee is unanimously of the view that the conquest of cancer is a realistic goal, if an effective national program along the lines in the report is promptly initiated and relentlessly pursued."


The report recommended cancer research spending of \$400 million in the 1972 fiscal year, and increasing it by \$100 million to \$150 million in subsequent years to a \$1 billion level in 1976. The consultants said that the program should be devoted primarily to research into the causes and cures of cancer, rather than to patient care.

The National Advisory Cancer Council's

fourth annual report cited the more than 60,000 deaths a year in the United States from an "epidemic" of lung cancer attributed mainly to cigarette smoking. The report also dealt with the chemical causes of cancer and the effects of many environmental factors, not only the "private pollution" of smoking, but also public air pollution from industrial and commercial wastes as causative agents.

Now effective is a ban on all advertising of cigarettes on television and radio. All packages of cigarettes manufactured and sold in the United States must carry a new warning: "The Surgeon General has determined that cigarette smoking is dangerous to your health." This replaced the milder warning required by a 1965 law that expired in 1969 which said: "Caution: Cigarette smoking may be hazardous to your health."

The report also explained that the production of cancer by chemicals is part of a larger problem of the hazards facing man in a polluted environment. The report pointed out that the death rate from cancer continues to increase despite improvement in the cure rate and suggested that this may be related to increased exposure of the population to cancer-causing agents in the environment.



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the compatible vasodilator

- no reported increase of intraocular pressure.
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.
- complications in the treatment of coronary insufficiency, hypertension, diabetes, peptic ulcer or liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators¹⁻⁴ have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement^{2,4} and observation of clinical improvement.^{1,3}

Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebotic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODILAN tablets, isoxsuprine HCl 10 mg. and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories. References: 1. Clarkson, I. S., and LePere, D. M.: *Angiology* 11:190-192 (June) 1960. 2. Horton, G. E., and Johnson, P. C., Jr.: *Angiology* 15:70-74 (Feb.) 1964. 3. Dhrymiotis, A. D., and Whittier, J. R.: *Curr. Ther. Res.* 4:124-128 (April) 1962. 4. Whittier, J. R.: *Angiology* 15:82-87 (Feb.) 1964.

Mead Johnson
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The Doctor

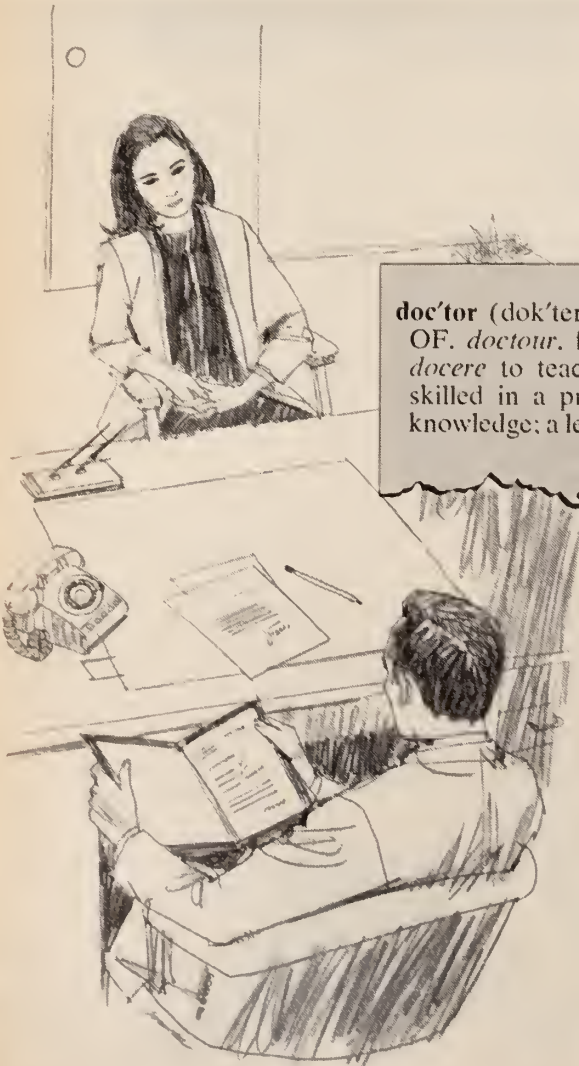
One of the doctor's most important roles is in education.

For his patients, the doctor provides the facts, supplies the rationale, triggers the action for life-saving health practices. To his students, he passes on his knowledge and the benefits of his clinical experience. With his colleagues, he shares new information and concepts.

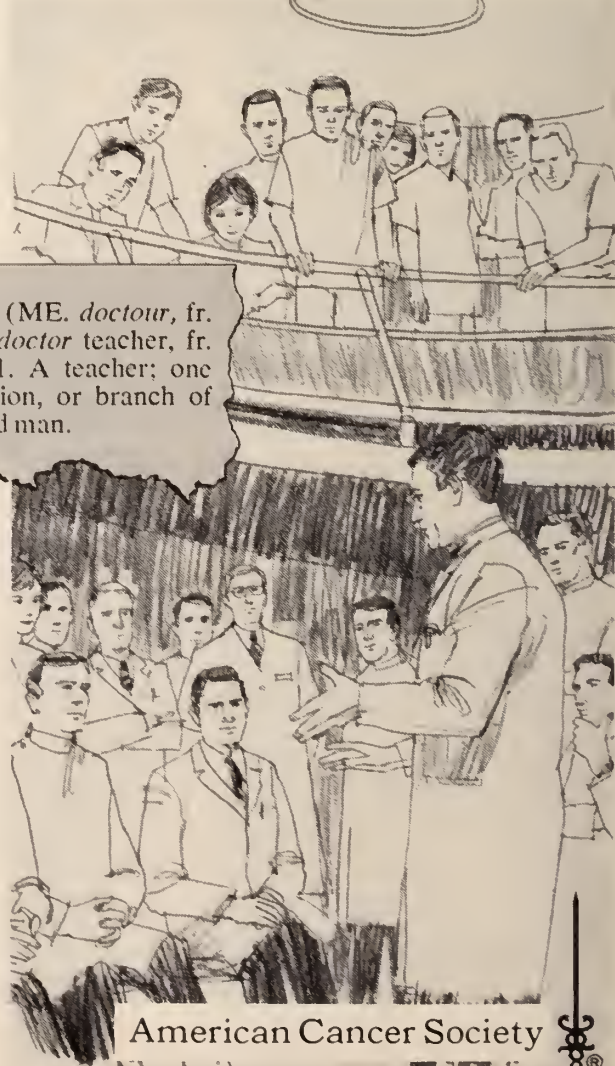
Assisting the doctor in his teaching role is

a major function of our professional education program. Through medical conferences, films, exhibits, pamphlets, monographs and other publications, we provide him with the most important and current information on cancer.

If, as Henry Brooks Adams speculated, "A teacher affects eternity; he can never tell where his influence stops", the outlook is optimistic.



doc'tor (dok'ter), *n.* (ME. *doctour*, fr. OF. *doctour*, fr.L. *doctor* teacher, fr. *docere* to teach.) 1. A teacher; one skilled in a profession, or branch of knowledge; a learned man.




American Cancer Society





There's a soup
for almost every patient and diet
...for every meal
and, it's made by *Campbell*



An excerpt
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of a new series
from Searle*

“The Ecology of Birth Control”

75 million more Americans— what impact on health care?

Because of a declining birthrate in the United States — attributable in no small measure to the widespread use of contraceptives — our population in thirty years is expected to be *only* 280 million, while the world population is expected to double, reaching 7 billion.

But the word “only” has an ironic ring to ecologists who warn of cities re-

sembling overcrowded, contaminated rat colonies, of respiratory and mental diseases reaching epidemic proportions and of a health-care community virtually overwhelmed by the burden.

The global consequences may be no less devastating. Ecologists estimate that every American has roughly fifty times the negative impact on the Earth's life-support systems of, say, a citizen of India. In these terms, adding 75 million Americans would be equivalent to adding 3.7 billion Indians to

the world population.

**For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative. Explored in the forthcoming issues will be the role of birth control on family pressures and its effects on the family; the influences of poverty, ethnic factors and marital status; its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.*

An original contribution
to the science of contraception

Demulen®

Each tablet contains 1 mg. ethynodiol diacetate/50 mcg. ethinyl estradiol

Demulen...for low estrogen and Searle's progestin...with its unsurpassed contraceptive effectiveness and low incidence of side effects...with simple "Sunday-starting" and patient-proof Compack® tablet dispenser.

Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FHS) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in sub-primate species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain¹⁻³ leading to this conclusion, and one⁴ in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors,

some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted; anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfolobomophthalen retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X, thyroid function: increase in PBI and butanol extractable protein bound iodine; and decrease in T₃ uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov.) 1969.

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Relieves G.I. gas distress*

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

March 21, 1971

A regular meeting of the Board of Trustees was held on March 21, 1971, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Hunterdon County Medical Society Sesquicentennial . . . Directed that an appropriate plaque be presented to the President of the Hunterdon County Medical Society at the opening session of the House of Delegates, May 15, in recognition of the sesquicentennial of that component Society.

AMA Conference on Health Quackery-Chiropractic . . . Designated James S. Todd, M.D. to represent MSNJ at the AMA Northeast Regional Conference on Health Quackery-Chiropractic on May 7 in Washington.

Council on Legislation . . . Approved the report of the February 25th meeting of the Council on Legislation, including the following recommended official position (as amended by the Board) of MSNJ on bills of medical import:

S-949 —To provide that a standard serological test for syphilis shall be a test approved by the Department of Health and shall be made in approved laboratories; to permit such laboratory tests to be made free of charge by the Department of Health. *APPROVED*

S-981 —To provide for the establishment of a central registry of blood donors in the State Department of Health and to appropriate \$50,000. *DISAPPROVED* because it would be a duplication of record keeping by existing blood banks in the State of New Jersey, with no appreciable advantages.

S-982 —To prohibit application of lead paint to toys, furniture or the interior surfaces of any dwelling, dwelling unit, rooming house, rooming unit or facility occupied or used by children, and to prohibit sale or delivery of toys or furniture to which lead paint has been applied. (Same as S-988) *APPROVED*

S-993 —To amend and supplement the "New Jersey Controlled Dangerous Substances Act," (S-851 of 1970) Law, Chapter 226 *APPROVED*

S-994 —To permit freeholders to contract with duly incorporated charitable organizations for maintenance of narcotic treatment programs. *APPROVED*

S-998 —To prohibit application of lead paint in interior of dwellings in which children reside and to prohibit sale, transfer, or delivery of toys and furniture which have lead paint. (Same as S-982) *APPROVED*

S-2015 —To provide that all members of professional boards and commissions shall be appointed by the Governor, to provide for an additional member to such boards and commissions who shall be a public member, and to provide for designation by the Governor of a head of a department closely related to such professions to be a member of the boards or commissions. *ACTIVE OPPOSITION*, because professionally unqualified lay members would encumber the boards with no appreciable advantage to the public and the present system of nomination of members to the State Board of Medical Examiners is superior to that proposed.

(Note: Signed by Governor March 25, Chapter 60)

S-2032 —To remove the residency requirement for county medical examiners. (Same as A-2056) *APPROVED*

S-2057 —To authorize boards of education to provide sex education for pupils in 7th through 12th grades. *DISAPPROVED*, because it would prevent any program of sex education below the 7th grade, where it is most needed.

S-2069 —To authorize the control of community noise levels; empowering the State Department of Environmental Protection to promulgate regulations for such purpose, and making an appropriation. *APPROVED*

S-2079 —To provide that any person who smokes in a railroad passenger car in which a "No Smoking" sign is posted is a disorderly person. *APPROVED*

S-2083 —To permit licensing of graduates of foreign medical schools to practice medicine in the United States after one year of internship in a hospital. *DISAPPROVED* because a section of the bill is so broadly drawn that it would authorize and encourage interns and residents to serve in hospitals anywhere in the United States, Canada, or in foreign countries, and could result in a decrease rather than an increase in interns and residents in New Jersey.

(Note: The Board amended the recommended position on S-2083 from approved to disapproved for the reasons indicated.)

- S-2084—To provide that applications for commitment for treatment of drug addiction by minors shall be valid and binding as if the minor had attained the age of 21 years. *APPROVED*
- S-2088—To provide for a Health Care Administration Board in the Department of Health with the Commissioners of Health and Insurance as ex-officio members, to authorize the Commissioner of Health to inquire into the operation and conduct inspections of medical care facilities, to adopt regulations, to provide for licensing and to transfer all functions related to administration of laws concerning boarding homes for sheltered care, care of children and adults, private mental hospitals, convalescent homes, private nursing homes, and private hospitals from the Department of Institutions and Agencies to the Department of Health. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES*, because it poses a threat to the free practice of medicine, concentrates excessive power in the hands of one person, and jeopardizes the continuance of the life and operation of the Medical-Surgical Plan of New Jersey (New Jersey Blue Shield).
- S-2091—To redefine "unnecessary radiation" under the "Radiation Protection Act"; to provide for the Commission of Radiation Protection in the Department of Environmental Protection in place of the Department of Health and to permit an embargo of any material or machine which is a radiation hazard. *APPROVED*
- S-2100—To delete provisions of the New Jersey Medical Assistance and Health Services Act providing for payment of claims through a fiscal agent or by direct administration by the Department of Institutions and Agencies. (Same as A-2122) *NO ACTION*
- S-2103—To permit any minor suffering from use of drugs and who is dependent upon drugs to consent to medical treatment. *APPROVED*
- SJR-2001—To create a commission to ascertain and devise the most practicable method of establishing a judicial mechanism for dealing with drug addicts and others whose personal accountability for their actions is impaired by their psychological condition. *NO ACTION*
- SJR-2003—To declare the month of May, 1971, as "Venereal Disease Awareness Month." *APPROVED*
- Note:* The Board amended the recommended position on SJR-2003 from no action to approved.
- A-496—To provide for regulation of use of safety glazing material and to direct the Commissioner of Labor and Industry to promulgate safety standards. *APPROVED*
- A-1203—This bill would transfer all powers, duties and responsibilities of the State Board of Control, the Hospital Licensing Board, the Commissioner of Institutions and Agencies and the Department of Institutions and Agencies related to medical care facilities to the State Department of Health. (Substitute for A-941) *APPROVED*
- A-1312—To appropriate \$1,000,000 to the Department of Health for family planning and related services. *NO ACTION*
- A-1323—To prohibit the littering of waterways and adjacent shores and beaches and to regulate marine toilets and to repeal Chapter 13, P.L. 1954 and Chapter 170, P.L. 1958. *APPROVED*
- A-1337—To require all persons riding in the front seat of an automobile manufactured after July 1, 1966 to wear seat safety belts. *DISAPPROVED* because there are certain medical conditions in which the wearing of seat belts is contra-indicated.
- A-1354—To require public school buses and other motor vehicles used to transport children to and from school to be equipped with seat belts for every seat. *APPROVED*
- A-1386—To provide for the regulation and control of pesticides by the Department of Environmental Protection and to establish a Pesticide Control Council. *APPROVED*
- A-2001—To permit blind persons with trained seeing-eye dog guides to enter into all public places. *APPROVED*
- A-2037—To provide that no person shall store or drain or dispose of dangerous or toxic chemicals in or on the soil unless the soil is protected by a dike or shield and unless an annual permit is obtained from the Commissioner of Environmental Protection. *APPROVED*
- A-2038—To prescribe criminal penalties for atrocious assault and battery on police, firemen, volunteer firemen and ambulance, rescue, first-aid or emergency squad personnel. *APPROVED*
- A-2039—To provide for appointment of a member of the New Jersey Industrial Nurses Association to the State Board of Examiners of Nurses. *NO ACTION*
- A-2055—To provide that the State Rehabilitation Commission shall administer a program of vocational rehabilitation to severely handicapped persons and shall institute and administer a program of extended employment in a sheltered workshop. *APPROVED*
- A-2056—To delete the requirement that the county medical examiner shall be a resident of the county in which appointed. (Same as S-2032) *APPROVED*
- A-2060—To create the New Jersey Medical Education Loan Fund in the Department of Higher Education. *ACTIVE SUPPORT*
- A-2061—To provide that the Board of Nursing shall not suspend a temporary permit to any foreign nurse to practice professional nursing solely because such nurse failed to pass a nursing examination given by the Board. *NO ACTION*
- A-2073—To require issuance of a plenary license to practice medicine and surgery to persons achieving a 75% average in examinations given by the Medical Examining Board. *ACTION DEFERRED* because this measure elim-

inates the discretionary powers of the State Board of Medical Examiners. The Council referred this bill to the State Board of Medical Examiners for its opinion.

A-2079—To authorize the Public Utilities Commission to regulate and control radioactive material, waste and by-product material and to provide for licensing and filing of annual reports. *DISAPPROVED* because this bill is in conflict with C. 33 of the Laws of 1970, transferring power to control unnecessary radiation from the Department of Health to the Department of Environmental Protection.

A-2094—To permit medical payments for children in foster homes, where placed by private non-profit agencies, under the medical assistance program. *APPROVED*

A-2098—To provide that illnesses caused by hypertension, heart disease, tuberculosis, including coronary thrombosis, shall be deemed an occupational disease of fire and policemen. *DISAPPROVED* because this bill involves diagnosis by legislation rather than by medical examination.

A-2099—To provide that under C. 255, P.L. 1944 hypertension, heart disease, tuberculosis suffered by fire and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED* because this bill involves diagnosis by legislation rather than by medical examination.

A-2100—To provide under C. 253, P.L. 1944 that hypertension, heart disease, tuberculosis suffered by fire and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED* because this bill involves diagnosis by legislation rather than by medical examination.

A-2102—To permit examination of a person for a bio-analytical laboratory director's license who demonstrates that he has acquired through experience or through experience and schooling the requirements set forth in the Bio-analytical Laboratory and Laboratory Director's Act. *DISAPPROVED* because there is no justification for the lowering of standards provided by existing statutes, since these standards are essential for the protection of the public.

A-2107—To require labeling of any soap, soap powder, or detergent as to phosphate content; declares any violator a disorderly person. *APPROVED*

A-2115—To provide that possession of more than 5 grams of marijuana or any amount of hashish shall be a high misdemeanor. *NO ACTION*

A-2122—To delete provisions of the New Jersey Medical Assistance and Health Services Act providing for payment of claims through a fiscal agent or by direct administration by the Department of Institutions and Agencies. *NO ACTION*

A-2131—To provide that no hospital which receives funds under the Medical Assistance and Health Services Act shall require as a condition to serving an internship an examina-

tion other than that required by the State Board of Medical Examiners. *DISAPPROVED* because enactment of this legislation would ultimately result in the withdrawal of approval of internships and residencies in hospitals that act in accordance with its provisions.

Note: The Board amended the recommended position from no action to disapproved for the reasons indicated.

A-2132—To provide under the Air Pollution Control Act that noise shall be considered an air contaminant and at a level greater than 108 perceived noise decibels shall be a prima facie evidence of air pollution. *APPROVED*

A-2135—To permit freeholders in a county which has no county home or hospital for children afflicted with sickle cell anemia to appropriate not more than \$5,000 each year for diagnosis and treatment of such children, provided freeholders in a first class county with population over 800,000 may appropriate not more than \$10,000 each year. *APPROVED*

A-2165—Concerning pensions of police and firemen, to define a traumatic event as applicable to any personal injury by accident arising out of and in the course of employment without regard to negligence of the employee except in cases of willfully self-inflicted injury or intoxication is the proximate cause of injury and the test shall be whether the actual work effort contributed materially to the disability sustained. *NO ACTION*

A-2181—To provide for the "Noise Control Act" and to empower the Department of Environmental Protection to promulgate codes and regulations. *APPROVED*

AJR-2002 —To declare March 7-13 as "Save Your Vision Week." *APPROVED*

ACR-2005—To amend the New Jersey Constitution, after referendum, to provide that all proceeds from the State Lottery shall go to aid for education instead of for State institutions. *DISAPPROVED* because this bill would divert revenues from the State Lottery presently earmarked for both mental health and educational programs solely to the field of education.

AR-20 —To direct the Department of Environmental Protection to conduct a study of the effects of steam emission into the atmosphere upon the ecology and environment of the State and to formulate appropriate regulations. *NO ACTION*

... Recommended that the following be noted and filed:

A-1334—To appropriate \$210,000 to the Department of Agriculture for the New Jersey Meat and Poultry Inspection Act for the period January 1 to June 30, 1971. *LAW, CHAPTER 321*

A-1359—To appropriate \$2,900,000 to the Department of Higher Education for costs of operation of Martland Hospital pursuant to its

contract with the New Jersey College of Medicine and Dentistry.

A-2030—To require public utilities to promulgate and file with the Public Utilities Commission written safety rules and regulations for handling of high voltage utility equipment and to furnish copies to employees and sub-contractors.

ACR-2011—To amend the New Jersey Constitution, after referendum, to provide that each person has a right to live in and the duty to promote a healthful environment.

Council on Mental Health . . . Approved, as amended, the report of the February 24th meeting of the Council on Mental Health, including the following recommendations:

1. That The Medical Society of New Jersey use all of its influence to have incorporated in the curricula of the appropriate department of the medical schools (Medicine and Psychiatry) a more adequate program devoted to the subject of alcoholism and, more specifically, the treatment of the alcoholic.
2. That MSNJ urge the Directors of Medical Education to include the treatment of alcoholism and the acute alcoholic in the appropriate approved residency programs.
3. That the Board of Trustees of The Medical Society of New Jersey, cognizant of the epidemic proportions of alcoholism, urge the State to make funds available to general hospitals to be utilized in postgraduate education programs for physicians in combating the chronic disease of alcoholism.
4. That the Board of Trustees of The Medical Society of New Jersey urge the Academy of Medicine to conduct educational programs for the practicing physician on the treatment of alcoholism.
5. That an outline prepared by Dr. Paul Fagan, Mountainside Hospital, Montclair, "The Practical Management of the Acute Alcoholic," he referred to the Editor of *The Journal*, to be used at his discretion, with Dr. Fagan's authorization, as an informational item in *The Journal*.
6. That the Council on Mental Health move to change the name of the Committee on Seizures to the "Special Committee on Neurological and Related Disorders."

. . . Directed that a congratulatory letter be sent to Dr. Robert S. Garber in recognition of his having been awarded the first Mount Airy Gold Medal for "distinction and excellence in psychiatry."

Anti-Diabetic Medications . . . Approved the recommendation of the Council on Public Health that the Board of Trustees consider the recent FDA action concerning oral hypoglycemic drugs along the following lines and issue a protest to the Food and Drug Administration.

1. The University Group Diabetes Program Study, which cost \$7,000,000 and almost ten years of work, had many good features. However, experts question the validity of the interpretation of the data because of deficiencies in homogeneity in baseline cardiac risk factors, the techniques of statistical analysis, the arbitrary and atypical mode of treatment of patients, the sweeping extrapolation of the results to the whole universe of diabetic patients, and the condemnation of the whole spectrum of oral hypoglycemic drugs, despite the fact that only tolbutamide, and, for a shorter period, phenformin were studied.
2. The uncritical and premature recommendations of the Food and Drug Administration on the treatment of diabetes in the Food and Drug Administration Current Drug Information letter (October 1970) to physicians are confusing, impractical, and a disservice.
3. The Food and Drug Administration was over-hearing and short-sighted in requiring a change of package insert by manufacturers of oral hypoglycemic drugs, despite the request to the contrary of an important group of diabetes specialists.
4. Releases by the public media (press, radio, and T.V.) were out of context and frightening, placing physicians in an embarrassing and compromising position when they had no printed scientific material to read on the subject.
5. The poor judgment and ill-conceived actions described above have shaken the foundations of good medical and public health practice in the control of this chronic metabolic disorder, and have resulted in a danger to the conception and completion of clinical research itself in the future.
6. Finally, this unwise interference with the physician's care of his patients by a governmental regulatory agency represents the practice of medicine "by fiat," while the physician has no protection from unjustified legal action.

Emergency Medical Care . . . Approved the report of the February 17th meeting of the Committee on Emergency Medical Care, including the following recommendations:

1. That a communication be sent to each county medical society urging it to take the leadership in the formation of a Community Emergency Medical Council.
2. That the Board of Trustees recommend to the Division of Emergency Health Services, U.S. Public Health Service, that 20-25% of the cots and blankets in the Packaged Disaster Hospitals located in New Jersey be allocated to those emergency departments in New Jersey hospitals willing to accept them for use in case of disaster and to be responsible for their availability at all times.
3. That the Board of Trustees approve in principle the program to train emergency room physicians in certain highly technical procedures and that the Committee on Emergency Medical Care be authorized to explore funding possibilities with the previously mentioned sources. It is understood that all specifics as to topics, format, and funding will be submitted, when available, to the Board of Trustees for final approval.

Conference of Presidents of Component Societies . . . Met with representatives of 18 component societies and discussed briefly the following items of significance: (1) first-aid station for legislators; (2) AMA dues; (3) financial support of the Academy of Medicine; (4) foundation practice of medicine and peer review; (5) blood procurement problems; (6) S-752—"Blood is a service not a product"; (7) compulsory voting by all members for officers of county societies; (8) S-706—enabling insurance carriers to sue physician when treatment unsatisfactory and award given patient is excessive; (9) S-2015—see page 433, this issue; (10) A-2131—see page 435, this issue; (11) proposed professional liability rate increase; (12) medical society membership for medical students; (13) Blue Cross/Blue Shield coverage under group plan for children in college past the present 19 year age limit; (14) Blue Cross coverage with MSNJ as a group; (15) direct payment by MSP for "Prevailing Fee Participating Physician;" (16) statement regarding "Principles of Patient Care;" (17) standardized insurance forms; (18) public relations efforts in the area of educational releases; and (19) medicaid.

Health Careers Exhibit . . . Approved a report from Dr. John Scillieri outlining specific details, including costs, of a MSNJ sponsored broad health careers series of exhibits at the NJEA convention, and authorized Dr. Scillieri to implement the project within the cost limits estimated. (At its February 21st meeting, the Board had approved the project in principle and requested specific details from Dr. Scillieri.)

Expansion of Executive Offices . . . Authorized an initial expenditure of \$450 for the preparation by selected architects of preliminary plans for the expansion of Executive Offices.

Utilization Review under Medicare and Medicaid . . . Approved the following guidelines for utilization review committees under Medicare and Medicaid (which were submitted by the Council on Medical Services) and recommended that they be reported to the 1971 House of Delegates.

Formation, Functions, and Responsibilities of Utilization Review Committees

Peer review as applied to the profession of medicine means that all investigation and evaluation of the services and activities of physicians is made by other physicians. This term is generic. There are many facets of medicine open to peer review; Credentials Committees and Tissue Committees are but two examples. Utilization review is another, as is the quality of care provided. These latter two aspects are of great current interest because of third party payer concern.

Preamble: There seems to be some misunderstanding and possible disagreement concerning the above title. Some persons and some medical societies have Utilization Committees (serving in hospitals) and also Review Committees at county medical or state society level, which go beyond utilization and actually resemble our State Society Judicial Mechanism to some extent in that they consider fee disputes which they arbitrate. In New Jersey we believe that a proper mechanism exists in our Judicial Council to adjudicate and arbitrate, and respond to patient, doctor, hospital, and third party payer complaints.

We shall consider hospital-based and county medical society-formed Utilization Review Committees as essentially the same. Their formation would be different as elected or appointed by hospital staff or county medical society, but their operation similar.

The Utilization Review Committee should be concerned not only with Medicare, Medicaid, and other third party paid patients, but with all occupants of hospital and Extended Care Facility beds. The Utilization Review Committee should devote particular attention to:

1. Unnecessary admissions
2. Excessive length of in-patient stay
3. Delay in use or over-use of x-ray, laboratory, and other diagnostic and therapeutic services
4. Delay in consultation or referral

In addition, the Committee should study patterns of care, i.e., studies ordered, treatment rendered, frequency of complications, length of stay of particular category compared to AID or PAS.

The Utilization Review Committee should have no enforcement or punitive powers of its own; it should be advisory and educational to all parties concerned.

The Utilization Review Committee should work closely with Medical Records Committee, the Tissue Committee, and OR, Admissions, Pharmacy, and other medical staff committees. Thought should be considered to including the functions of medical audit, tissue review, and infection control committees into the Utilization Review Committee.

The Utilization Review Committee should conduct an on-going current review of charts, not alone a study of discharged patient's charts.

The Utilization Review Committee should make recommendations to appropriate medical staff committees, chiefs of services, or admissions regarding the following:

Administration:

1. Institute methods to overcome delays in transmitting orders and carrying out various diagnostic and therapeutic procedures

2. Overcome inadequate weekend and night coverage of facilities
3. Strengthen Social Service
4. Integrate admission schedule and OR schedule
5. Increase the availability of ambulatory patient services

Chief of Service:

1. Analysis of cases indicating delay or neglect in obtaining consultation
2. Analysis of wide variations in length of stay of cases with same diagnosis
3. Consideration of unnecessary hospital admissions
4. Consideration of unnecessary utilization of lab, x-ray, and other ancillary services.
5. Duplication or excessive use of multiple physicians

The Utilization Review Committee should make regular reports and have regular meetings with minutes available for proper authorities; the Utilization Review Committee should develop appropriate forms and checklists in order to facilitate its operation.

The county medical society Utilization Review Committee would properly function in Extended Care Facilities and in smaller hospitals with no Utilization Review Committees of their own.

The possibility of one hospital's Utilization Review Committee working in another hospital should not be overlooked. This would not only be an enlightening experience but would forestall the governmental approach to peer review.

The Utilization Review Committee should be able to prove that it actually does influence effective utilization for the better.

AMA Workshop on Peer Review . . . Directed that MSNJ be officially represented at the AMA National Workshop and Conference on Peer Review to be held May 21 and 22 in Chicago—representative to be designated by the President.

New Jersey MDs In The American Revolution

We have been invited by the Pennsylvania Medical Society to display, in Philadelphia, medico-historical documents relating to New Jersey and the American Revolution. Most of this material is already in public repositories, such as the university and state libraries and the historical societies, but we believe that there may be some letters, diaries, and other memorabilia still in private hands. In order to prepare a census of the available material, we are publishing herewith what we believe to be the most complete list of medical men

of New Jersey who served actively in one capacity or another with the armed forces during the years 1776 to 1783. We urge our members to scan this list and obtain any information which might be of interest from lineal or collateral descendants. All correspondence should be addressed to Morris H. Saffron, M.D., Chairman, Committee on the National Bicentennial Celebration of 1976, The Medical Society of New Jersey, P. O. Box 904, Trenton 08605.

Commissioned Surgeons

Andrews, John	Horton, Jonathan
Appleton, Abraham*	Howell, Lewis
Ball, Stephen*	Hubbard, Jacob
Barnet, Oliver	Jennings, Jacob
Bloomfield, Moses	Johnes, Timothy
Burnet, William	Johnson, Usal
Burnet, William, Jr.	Loring, Ephraim*
Campbell, George W.	McCarter, Charles
Campfield, Jabez	Morris, Jonathan F.
Cochran, John	Otto, Frederick
Condit, John	Otto, Bodo, Jr.
Craven, Gershom	Patterson, Robert*
Cummins, Robert	Pearson, David
Darcy, John*	Reed, Thomas C.
Dunham, Lewis F.	Roach, Nicholas
Elmer, Ebenezer	Riker, John B.
Elmer, Moses G.*	Schenck, Henry H.
English, James	Scott, Moses
Ervin, David	Scudder, John A.*
Ewing, Thomas	Stockton, Benjamin B.*
Freeman, Melancthon	Stockton, Ebenezer*
Hammell, John*	Tunison, Garrett W.
Hampton, John	Van Boskirk, Abraham
Harris, Isaac	Vickers, Samuel
Harris, Jacob	Wilson, Lewis
Hendry, Thomas	Winans, William
Holmes, James	Witherspoon, John

* Surgeon's mate

Non-Commissioned Surgeons

Bainbridge, Absalom	Draper, George
Baldwin, Cornelius	Edwards, Enoch
Barber, Thomas	Henderson, Thomas
Beaumont, H.	Henry, Robert R.
Bryant, William	Jones, Timothy
Budd, Berne	Murdock, James
Carter, Charles M.	Roan, ?
DeGeau, Walter	Rogue, John
Dorris, William B.	Ross, Alexander

Cabaret—May 15

Dinner-Dance—May 17

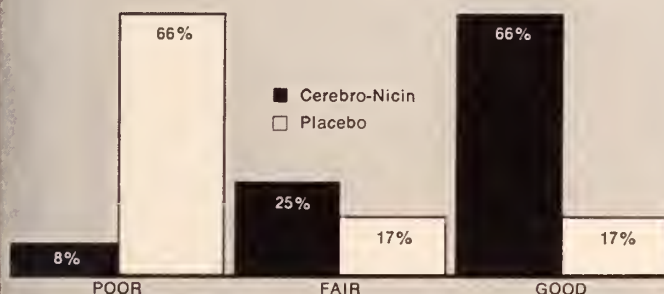
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

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Pentylentetrazole.....	100 mg.
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Ascorbic Acid.....	100 mg.
Thiamine HCl.....	50 mg.
L-Glutamic Acid.....	50 mg.
Niacinamide.....	5 mg.
Riboflavin.....	2 mg.
Pyridoxine.....	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

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Also elixir 8 oz. bottles.

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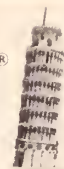
The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970 Official Journal of the American Fertility Society

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100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.



Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcaemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging of biliary canaliculi have occurred with average doses of Methyltestosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Larger dosages may cause anorexia, nausea, vomiting, abdominal pain, diarrhea, headache, dizziness, lethargy, parosmia, skin eruptions, loss of libido in males, gynecomastia, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyltestosterone, in particular elderly patients, should be observed for edema. Hypercalcaemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcaemia is detected.

References: 1. Monteleone, P. and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Quin, M. E. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tillet, A. S. Methyltestosterone thyroid in treating impotence. Geriatr 25:6, 1967. 4. Helman, L., Bradlow, H. L., Zuckerman, D., and Gallagher, T. F. Thyroid androgen interaction and the hypochloremic effect of androgen. J Clin Endocr 35:936, 1959. 5. Faris, E. J. and Colton, S. W. Effects of L-thyroxine and l-thyronine on spermatogenesis. J Biol 79:863, 1958. 6. Dail, A. and Farar, E. E. United States Dispensary, Inc. 25. Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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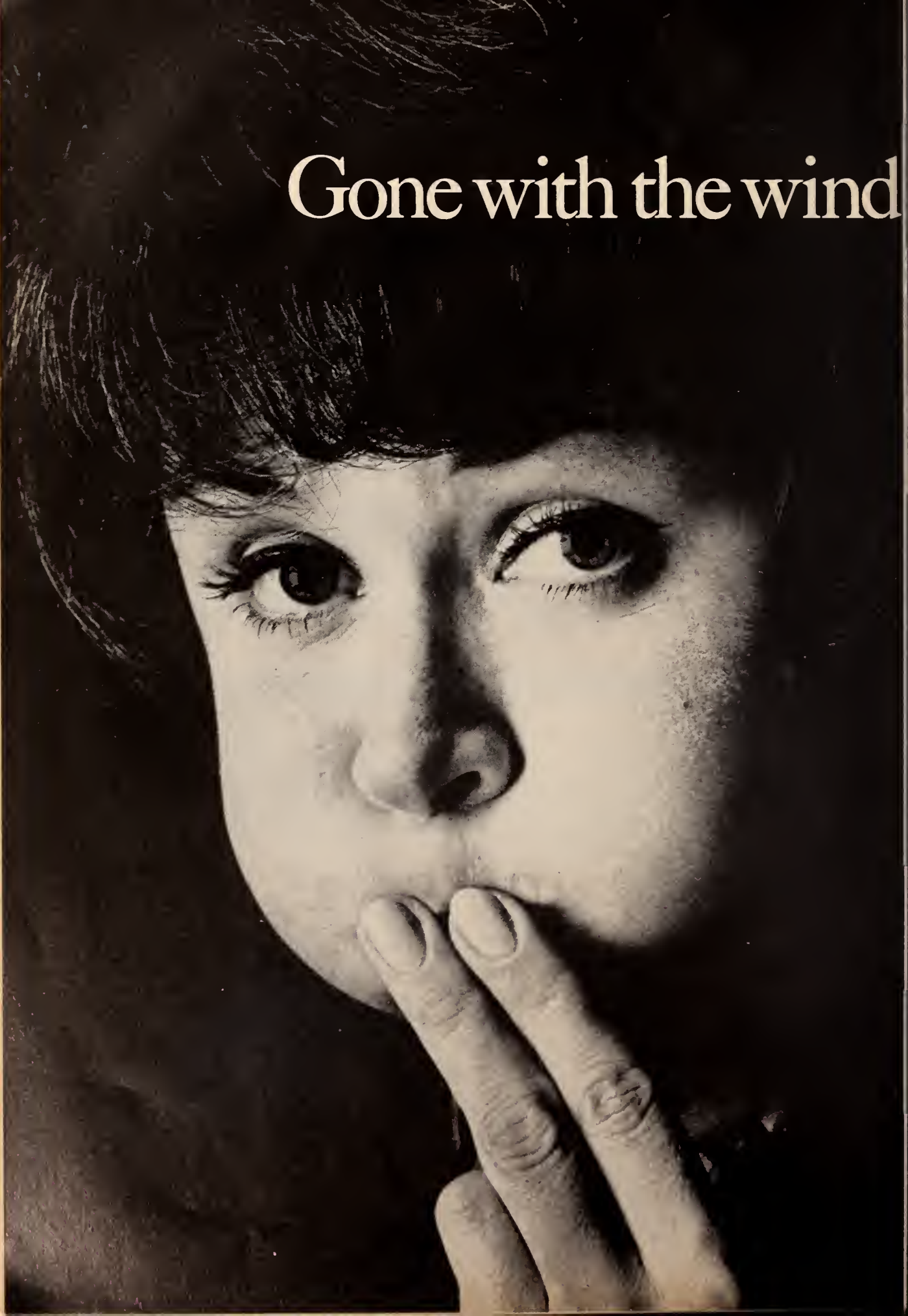
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*Slanger, A.: Med. Times 94:150 (Feb.) 1966.

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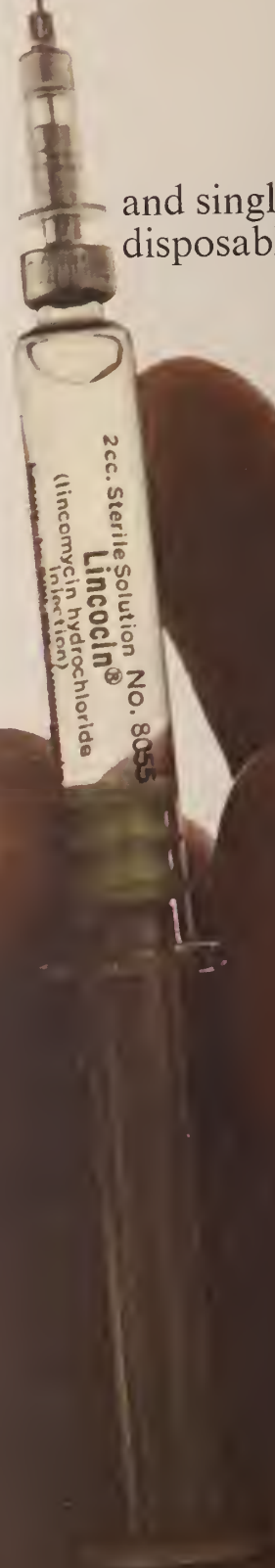
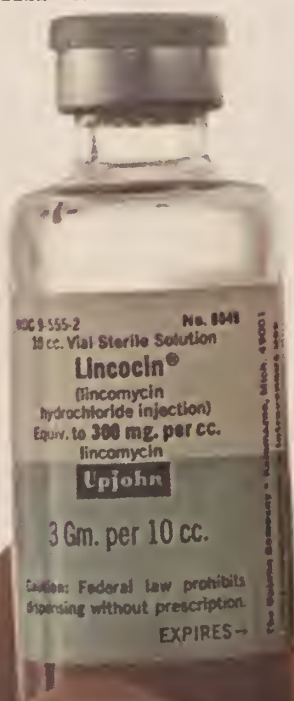
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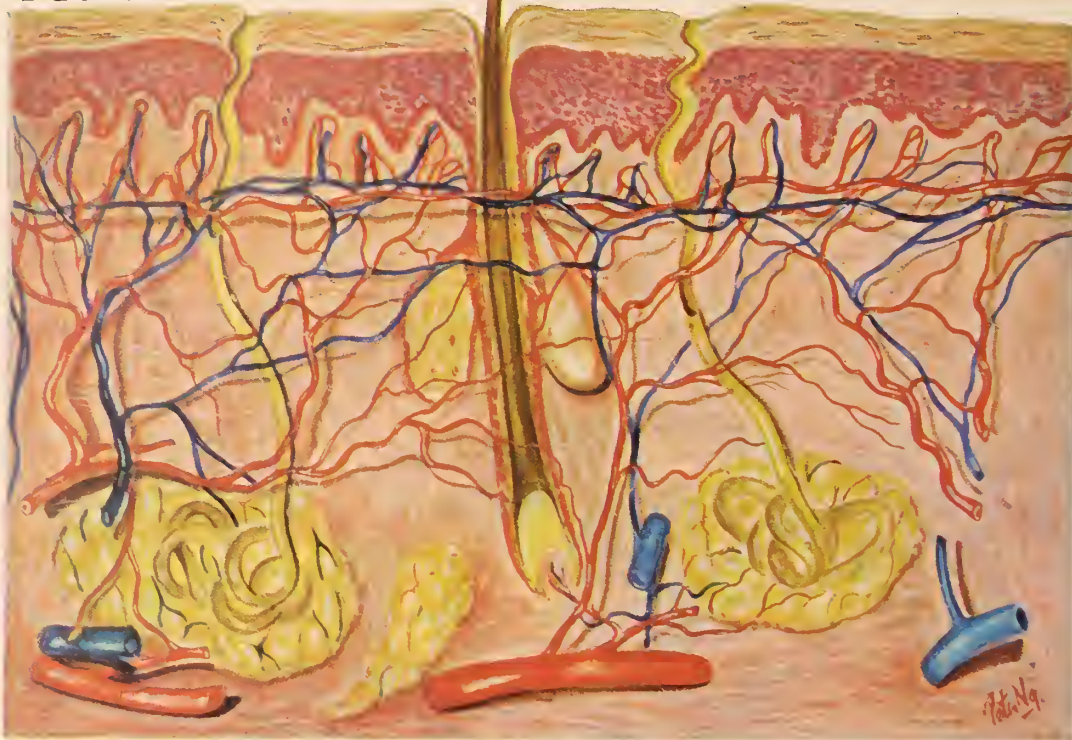
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Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during March 1971:

	1970 March	1971 March
Aseptic Meningitis	3	10
Primary Encephalitis	2	1
Post-Infectious	0	0
Hepatitis		
Total	178	317
Infectious	158	255
Serum	20	62
Malaria	6	8
Military	5	7
Civilian	1	1
Meningococcal Meningitis	9	11
Mumps	227	289
German Measles	253	72
Measles	319	139
Salmonella	26	27
Shigella	3	20

Hospital Infection Control Program

The State Department of Health sponsors an active infection control program for community hospitals in our state. The program is based upon the concepts of surveillance developed by the Center for Disease Control. It is coordinated by a surveillance officer (generally a registered nurse) who reports directly to the chairman of the hospital infection committee or to the pathologist. Surveillance activities are summarized in statistical reports of nosocomial infections which serve as an internal audit of the hospital's infection rates. These baseline data (by service, location, site of infection, and etiologic agent) permit early recognition of unusual clusters of hospital-associated infections so that control measures may be initiated. Twenty-five hospitals in New Jersey now actively participate in this program. Participation is entirely voluntary. Our Department is interested in helping hospitals provide quality patient care to New Jersey residents, and, without cost, will assist hospitals in establishing nosocomial infection control programs. Hospitals in the state interested in this program may communicate with Mrs. Catherine Lahey, R.N. by mail or by telephone (609-292-7300).

Meningococcal Infections—1970

During the calendar year 1970, 196 meningococcal infections were reported to the New Jersey State Department of Health. New Jersey residents accounted for 56 infections while military personnel and their dependents accounted for 140. The over-all 1970 figure is similar to the 191 cases reported during 1969; however, there was a 61 per cent increase in military cases while the number of civilian infections decreased 46 per cent compared to 1969. The 196 infections included 132 cases of meningitis and 64 cases of meningococcemia. There were eight deaths among the entire group, a case fatality rate of 4 per cent. Cases occurred in 16 of the state's 21 counties, but there were no clusters of cases among the civilian population and no cases reported from state institutions.

Only 47 per cent of the total meningococcal infections occurred during the period January through May. This is in contrast to previous years in which the majority of cases occurred during the winter and spring months. This change is accounted for by the peak in the number of military cases noted during the summer months, which is probably related to basic training activity. When examined separately the civilian cases followed the usual winter-spring seasonal pattern.

A total of 114 meningococcal isolates were tested for sulfadiazine sensitivity during 1970. Of these 89 per cent were resistant to a drug concentration of 1.0 mg per cent. There were 102 group C isolates, 99 of whom were resistant to sulfadiazine.

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205th Annual Meeting

Woman Of The Year

Dr. Berta D. Rados of East Orange, who last year received a Golden Merit Award from The Medical Society of New Jersey, has been honored as Woman of the Year by the New Jersey Medical Women's Association.

Dr. Rados, who was born in Russia and educated at the Medical School of the University of Zurich, Switzerland, came to the United States in 1920. During her 50 years in New Jersey she was an associate of the eye staff of the Beth Israel Hospital in Newark and, upon the death of her husband, she became Chief of the Eye Service. At the present time, she continues the private practice of ophthalmology in association with her son. She is certified by the American Board of Ophthalmology.

Behind The Drug Scene

(This column is prepared by Stanley Einstein, Ph.D., Coordinator, Drug Abuse Project, Martland Hospital Unit, CMDNJ, Newark, and Executive Director, Institute for the Study of Drug Addiction, New York City.)

Alternatives To Drug Abuse

More and more the public is turning to the physician for answers about the use and misuse of drugs. Under optimal circumstances, the physician may be prepared for the task of crisis intervention in terms of acute medical care. Some of the difficulties, however, are the unavailability of reliable specific treatments for the drug misuser, the gaps in medical and other health facilities and the potential jeopardizing of patients. These are examples of the difficulties that the physician faces in attempting effectively to intervene in the contemporary drug scene.

Asked to come up with viable alternatives to drug abuse, the physician is at the same loss for alternatives that everyone else is. This is not because there are no viable solutions. Rather it is because the question about *alternatives to drug abuse* is so huge in what it actually and potentially encompasses, that the

most immediate reaction to it is one of feeling overwhelmed. We need not succumb to this feeling.

Possible alternatives to drug abuse (and the roles that physicians can play in these alternatives) become more obvious when we begin to spell out what drug abuse is or may be. Drug abuse is not a single entity, nor a unitary concept. Indeed there are at least three sources of definitions for drug abuse. These are:

1. *Abusing Drug Laws*: the breaking of drug related laws, mores, and rituals by using particular drugs in particular ways and for particular reasons.

2. *Self Abuse*: the direct or indirect consequences of the use of drugs for other than medically approved reasons by the person taking them.

3. *Abuse of Others*: the direct or indirect consequences of the use of drugs for other than medically approved reasons on people other than the drug misuser.

Developing viable alternatives to drug abuse begins to be possible if we note the type of drug abuse we are considering at a given point in time. Decide next what the focus of intervention is to be. Examples of potential focusing can be: drugs, abstainers (those who never used drugs, as well as those who have ceased their drug misuse), drug users, intervention agents (be they teachers, clergy, treatment agents, parents, or peers), and the general community. We then decide the area of possible intervention. Acknowledging that the choices are arbitrary we nevertheless should consider the following potential areas: Treatment, Education, Attitudes, Media, Culture, Religion, Laws, Politics, Economics, and Research.

The table that is created by this type of consideration permits us to consider what we can and can't do, what our responsibilities and limitations are for each cell so that we don't get bogged down by the enormity of the initial task.

For example, what alternatives are available if our concern or mandate is to use *treatment* to intervene in the *breaking of drug laws* focusing upon *drugs*. One possibility might

be to offer methadone maintenance. This acceptable treatment, hopefully, should reduce the incidence of drug related arrest. It can reinforce the appropriate use of medicines and the inappropriate use of drugs. This is one possible alternative. I, a, C (to intervene in the *Abuse of Others* through *Treatment* by focusing upon *Drugs*—see last paragraph) may offer no viable alternatives at the present time.

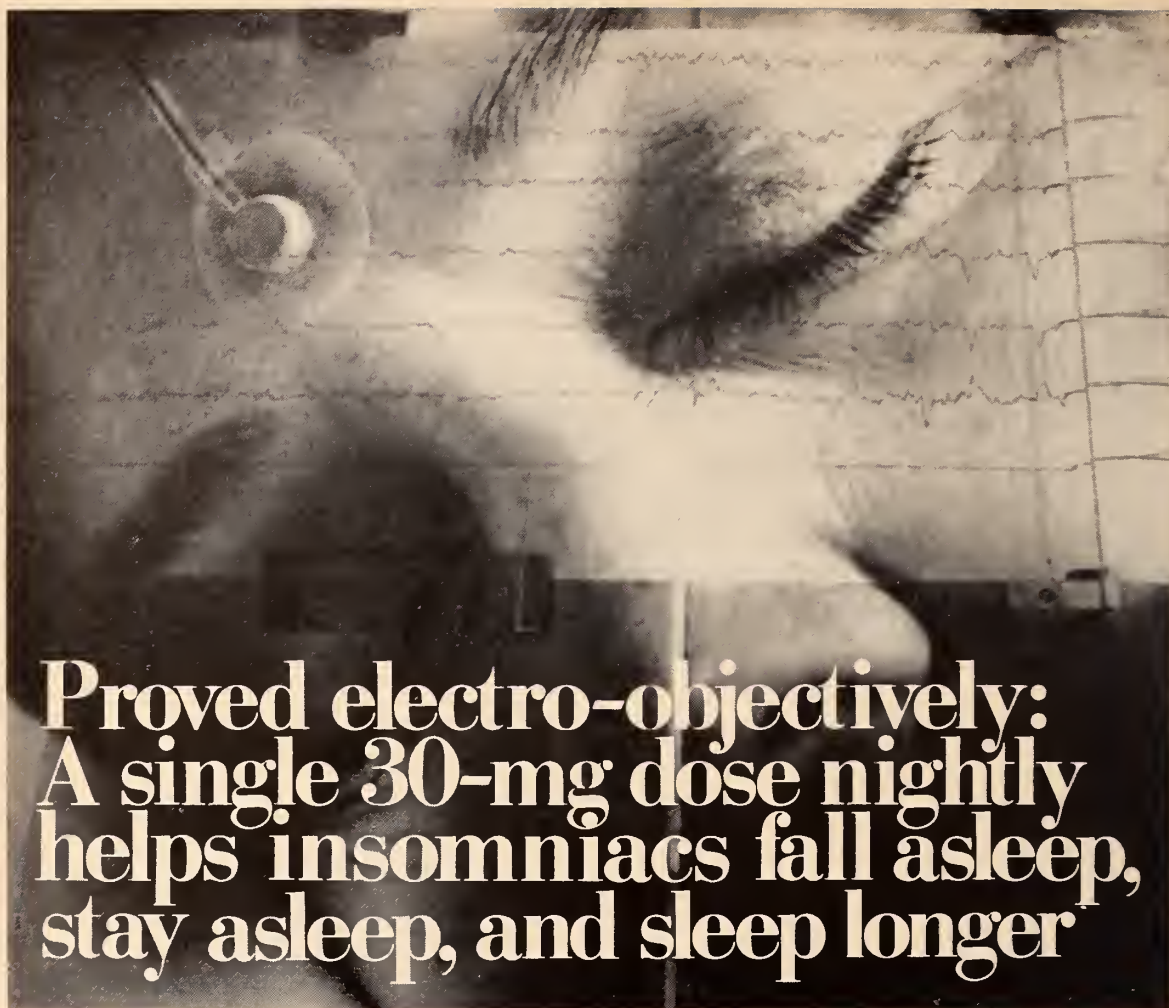
If there aren't any alternatives that we and our colleagues can come up with, then we move on to areas or cells which permit us to utilize our expertise, time, energy, and money. This is only an approach and not a guide to the dos and don'ts of drug abuse interven-

tion. It offers a framework to add to or delete from while permitting us to decide what role we can play and may choose to play in a contemporary problem area that is full of ambiguities.

It would be helpful if you would take the time to consider viable alternatives to drug abuse. Set these alternatives under one of three columns: (A) abuse of drugs related to laws and mores; (B) abuse related to self; and (C) abuse related to others. Consider these under each of the ten headings given in the following table—treatment, education, attitudes, and so on. Send them to Stanley Einstein, Ph.D., Drug Abuse Project, Martland Hospital Unit, CMDNJ, 65 Bergen Street, Newark.

Alternatives to Drug Abuse

Areas of Intervention	Focus of Intervention	Areas of Intervention	Focus of Intervention
I. Treatment (Including Early Case Finding and Prevention)	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community	VI. Religion	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community
II. Education	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community	VII. Laws, Policies, Procedures	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community
III. Attitudes	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community	VIII. Politics	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community
IV. Media	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community	IX. Economics	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community
V. Culture	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community	X. Research	a. Drugs b. Abstainers c. Drug Users d. Intervention Agents e. General Community



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Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.^{1,2,3}

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,¹ Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

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Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

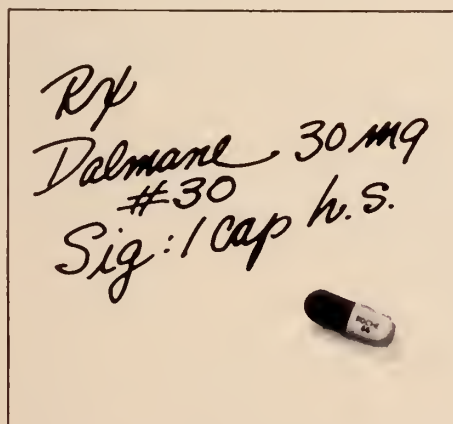
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.³ Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



For the sleep your patients need

New **Dalmane**[®]
(flurazepam hydrochloride)

Before prescribing, please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

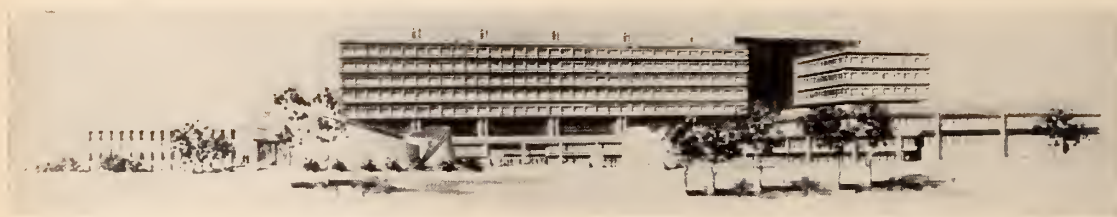
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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Comment From CMDNJN

Summer Research Programs

The scope and value of our summer student research program is increasing each year. More and more medical and dental students plus an expanding group of the faculty participate in this learning activity which adds a new dimension in the training of tomorrow's physicians and dentists. Foundations, pharmaceutical companies, voluntary health agencies, and other donors now provide staunch financial support to enable our students to devote their summer months to professional pursuits while receiving a modest stipend to help them meet the skyrocketing costs of their education.

The program is conducted by a faculty committee under the direction of Erich Hirschberg, Ph.D., Associate Dean of Research.

During the summer of 1970, 88 medical and 21 dental students carried out a wide variety of basic and clinical research projects under the guidance of 83 faculty members. Each student then prepared a report of his or her accomplishments. This is included in a College Report which is receiving wide distribution. Copies are available for the asking.

Please get in touch with Lee R. Munsick, Director of Professional Relations, CMDNJ at Newark, 100 Bergen Street, Newark 07103.

To highlight the major accomplishments of this program, a committee of faculty and outside consultants selected some of the most successful projects for presentation at the Third Annual Student Research Seminar on March 24, 1971. After welcoming remarks by John K. Kittredge, Chairman of the College Board of Trustees, the well-attended meeting heard sixteen speakers summarize their work.

Topics ranged from basic efforts in neuroanatomy, neuropharmacology, and cardiac physiology to contributions to major clinical problems in lead poisoning, wound infection, and serum hepatitis.

In addition to the honor of being selected by the program committee, the students also gained usable experience in the technics of summary and presentation of data at scientific and medical meetings.

Students are already signing up in large numbers for the 1971 summer research program. This will continue what has already become an established tradition in this young, rapidly growing institution.

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ANNOUNCEMENTS

Drug Training Institute in New Jersey

May 13, 14, and 15 have been allocated for a special drug training institute at the Chal-fonte-Haddon Hall in Atlantic City. This overlaps the MSNJ Annual Meeting at the same hotel. The \$50 registration fee includes two nights in the hotel. Thursday, May 13, opens with registration (6 to 8 p.m.), a training film, and an informal dinner caucus with the faculty. On Friday, May 14, a knowledgeable series of speakers will discuss the pharmacology of drug abuse, the medical complications and methods of crisis intervention, chemotherapeutic approaches to the management of addiction, and methadone maintenance. The evening lecture is called "Attitudes and Stereotypes." On Saturday, May 15, there will be presentations on physicians' attitudes toward the drug abuser, and a review of alternatives to drug abuse. A kit of highly practical, published materials will be distributed to registrants. This seminar is sponsored jointly by the Academy of Medicine, the College of Medicine and Dentistry of New Jersey at Newark, and Pfizer Laboratories.

The Jeghers Lecture

This year the Jeghers Lecture will be held at 3:30 p.m. on Friday, May 28, at the auditorium of the Nurses' Home at 117 Fairmount Avenue in Newark. Speaker will be William Bennet Bean, M.D., the well-known Professor of Medicine at the University of Iowa. This is in connection with the Alumni Day program of CMDNJN, which starts with Grand Rounds at 11:30 a.m. and concludes with a dinner-dance at the Chanticleer.

Conference With Voluntary Health Agencies

New Jersey physicians (together with those from New England states) are invited to attend the conference on medical society relationships with voluntary health agencies.

This colloquium will take place in Boston on Sunday, May 23, at the Statler Hilton Hotel. This is a theme that has not been much worked over at the many medical meetings held in the country these days, and it provides some refreshing approaches. For more details, write to Donald A. Dukelow, M.D., Council on Voluntary Health Agencies, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Cellular Antigens

Cellular Antigens will be reviewed in a colloquium this year, June 7, 8, and 9, in Philadelphia. The meetings will consist of six sessions dealing with the chemical and immunological aspects of cellular antigens: gram-negative antigens, gram-positive antigens, erythrocyte antigens, white blood cell antigens, normal tissue antigens, and malignant tissue antigens. For more information, write to the Department of Microbiology, Temple University School of Medicine, 3400 North Broad Street, Philadelphia 19140.

OB-GYN Cytology Course

Available to obstetricians and gynecologists is an intensive five-day course in cytology. This will be given four hours a day, the first program starting on May 10 and the last starting on June 14. The course is an introduction to the acridin orange 10-second fluorescence for cytology to be examined in the physician's office. Subjects include: specific and non-specific infections; detection of trichomonads, monilia, and an introduction to the appearance of abnormal cells. The course is given at Gyn Cytology and Pathology Associates, 117 Fort Lee Road, Leonia, New Jersey 07605, under the direction of Allan Lazar, M.D. and Karl Klinges, M.D. For further information call the laboratory at (201) 836-2070, or write to Dr. Lazar at 986 Teaneck Road, Teaneck 07666. Fee for the course is \$50.

Camp For Diabetic Children

New Jersey's only camp for children with diabetes—Camp Nejeda in Stillwater, New Jersey—is about to start its 14th season, June 27 to August 21. This camp is sponsored by our physician organization, the New Jersey Diabetes Association. It should not be confused with Camp Nyda. Brochures and applications are available for anyone interested. Requests for these should be made to Camp Nejeda, 317 Belleville Avenue, Bloomfield, New Jersey 07003. There are four sessions: June 27 to July 10; July 11 to July 24; July 25 to August 7; and August 8 to August 21.

Camp Nejeda is coeducational, for children 5 to 15 years of age. It is non-sectarian and accepts any child with diabetes regardless of ability to pay the full tuition (\$85 per week).

Research Fellowships in Parkinsonism

Interested medical students should be advised that three-month research fellowships in parkinsonism are available between July 1971 and June 1972. Each carries a \$750 stipend. If you know of any medical student interested in neurology have him write to the Parkinson's Disease Foundation at 640 West 168th Street, New York 10032, for more details.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

May

- 11 Academy of Medicine of New Jersey
Overlook Hospital, Summit
Diagnosis and Treatment of Shock
- 12 Academy of Medicine of New Jersey
University of Pennsylvania Medical
School, Philadelphia
Renal, Electrolyte, and Acid-base Disorders
- 13 Burlington County Memorial Hospital
Mount Holly
Management of Acute Drug Intoxication
- 15 The Medical Society of New Jersey
to Haddon Hall, Atlantic City
18 Annual Meeting
- 20 Burlington County Memorial Hospital
Mount Holly
Amniocentesis and Amnioinfusion in Preg-
nancy
- 26 Academy of Medicine of New Jersey
Mayfair Farms, West Orange
Annual Awards Dinner
- 27 Burlington County Memorial Hospital
Mount Holly
Breast Cancer

- 27 Academy of Medicine of New Jersey
and Radiological Society of New Jersey
Orange Memorial Hospital, Orange
Section Meeting

June

- 3-4 Saint Barnabas Medical Center
Department of Obstetrics and Gynecology, Livingston
Gynecologic Endoscopy
- 15 Associated Eye Residences of New
Jersey
Eye and Ear Infirmary, Newark
Tumors of Lids and Adnexa
- 24 Academy of Medicine of New Jersey
and Radiological Society of New Jersey
Orange Memorial Hospital, Orange
Section Meeting

October

- 25-29 Saint Barnabas Medical Center
Department of Obstetrics and Gynecology, Livingston
Obstetric and Gynecologic Pathology

The girth control pill



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Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy. Unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety

and jitteriness, and in rare cases depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in the morning (10 a.m.). TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in the evening to overcome night hunger. Use in children under 12 years of age is not recommended.

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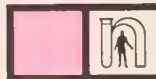
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One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

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Prescribing Information — Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



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Specific therapy for night leg cramps

LETTERS TO THE JOURNAL

Differential Liability Rates?

January 21, 1971

My dear Editor:

I believe that the insurance agent, our insurance committee, and our membership (including myself) completely forgot one phase of liability insurance. Some differential in premiums is enjoyed, according to the type of professional services covered, but nothing is mentioned offering a lower premium to those doctors whose past record as to the creation of claims is clean. Other forms of liability coverage commonly do so. Why not here?

I have had professional liability coverage for 46 years. During the first 41 of those years—until my associate and surgical assistant died within a few months of each other—I performed the vast majority of operations arising on my private patients. Yet, during all of those years, I have never had even one protest or question from any patient or patient's family (let alone a claim) arising from my medical or surgical services.

Is it equitable, or justifiable, that I should have to pay the same premium rate as those physicians who are claim-prone and have had a succession of claims? It would seem to me that those whose record shows them to be claim-prone should pay proportionately higher premiums. I believe that group coverage should terminate automatically, for those who have a succession of claims arising from their work, under a definite plan incorporated in the insurance contract. This sort of sliding scale of premium costs applies in my auto insurance.

Our Society, through its insurance committee, should demand that sort of fairness toward those who, like myself, are now paying unreasonably high premiums to compensate the

insurance company for the losses caused by claim-prone members. I have written our Society's agent that if the premium impost for next year be the same, or higher, I shall not want coverage. Why should I pay exorbitantly for liability coverage which I do not need, judging by my 46 years of liability-insured practice? And I don't believe that I am the only doctor in New Jersey who is in that situation.

(signed) Albert G. Hulett, M.D.

It's Not That Simple

March 10, 1971

Dear Doctor Davidson:

Medical professional liability insurance cannot be treated like other forms of casualty insurance. The insurance industry, in an effort to distribute more equitably the cost for this protection, established five separately rated classes of practice. Under our program we have seven classes each with different rates.

Medical professional liability insurance is not subject to the frequency rate usual in other liability forms of insurance. Most malpractice claims involve a greater degree of severity and consequently a higher exposure per claim to the insurance company.

Our statistics for the past ten years show an average of one law suit per year for each twenty insured physicians. This would indicate that the average physician would experience one law suit for each twenty years of practice. The frequency of suits for non-surgical practice is much lower and much higher for surgical specialties. The rates recognize this variance with the cost for the surgical specialty of five times that for non-surgery.

Over ninety per cent of all suits reported are against physicians or surgeons who have never had a previous one against them. Very few are for the same physicians or repeaters.

We have a surcharge provision in our program for those who experience more than one law suit in a period of ten years. The surcharge ranges from 50 per cent to 500 per cent additional premium for a three year period. However, we include only suits in which there is deviation from accepted standards as determined by our County Medical Review and Advisory Committee and with settlement value in excess of \$1,000. The additional premium from this source helps to offset the annual increase in premium charges.

A credit system, as suggested by Doctor Hullett, would be unreasonable eventually to

most of our members. For instance, for nineteen years the average physician would enjoy a reduction in cost. In the twentieth year, the average physician would receive his first law suit which could cost the insurance company \$100,000 or more. This average physician's cost would have to be increased astronomically to perhaps \$40,000 or \$50,000 annually for three years. Our present system of distribution of costs equitably between seven classes and a surcharge program is the best for all physicians.

(signed) Joseph A. Matt
for the Joseph A. Britton Agency

205th ANNUAL MEETING

May 15-18, 1971

Scientific Sessions—May 16 and 17

House of Delegates—May 15, 16, and 18

Exhibits—Informational, Scientific, Technical
May 15, 16, and 17

Cabaret—May 15

Dinner Dance—May 17

(See full program in April Journal)

The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance

to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

For details, write to the Society at P.O. Box 95, Belleville, New Jersey.

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1. Gordon, E. E. and Haas, A., *Indust. Med. & Surg.* 28:217, May, 1959.



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OBITUARIES

Dr. David B. Allman*

On March 30, 1971, David Bacharach Allman, M.D., died. He was a Fellow of The Medical Society of New Jersey and the only member of our Society to become AMA President (1957-1958). He was born in 1891, and was graduated from the Jefferson Medical College in 1914. He was a founder of, and a charter diplomate of, the American Board of Surgery. He was a Fellow of the American College of Surgeons. Dr. Allman held numerous offices in the Atlantic County component, and in the State Society he was a trustee and chairman of the Finance and Budget Committee. He was a member (and President) of the State Board of Medical Examiners. He served the Atlantic City Hospital all his professional life, and for decades was chief of surgery there. He was medical director of the Betty Bacharach Home for Crippled Children in Longport—it was named for his grandmother. Dr. Allman and his family were civic leaders in the Atlantic City area since World War I—his uncle, Harry Bacharach, was Mayor of Atlantic City for many terms.

Dr. Arturo R. Casilli

One of our state's pioneer pathologists died on March 10, with the passing that day of Arturo R. Casilli, M.D. Born in 1892, he was a 1914 graduate of the Medical School at the University of Maryland. He served all three hospitals in Elizabeth and, indeed, was largely responsible for the expansion of their pathology departments in the early 1920s. He was a Fellow of the American College of Physicians and a board diplomate in pathology. Dr. Casilli was, for many decades, active in the Union County Medical Society. He was a recipient of the MSNJ Golden Merit Award in 1964.

* Editorial comment on the passing of Dr. Allman will be found on page 359 of this issue

Dr. Anthony R. Comunale

The long and useful life of Anthony R. Comunale, M.D., came to an end on March 2, 1971, with the death that day of the 72-year-old industrial physician. Born in 1899, he received his M.D. from the University of Virginia's Medical School in 1928. During most of his professional life, Dr. Comunale was an industrial and occupational practitioner, but he also served in the emergency department of the Rahway Hospital and was a member of our Union County Medical Society.

Dr. Martin J. Eisenberg

On February 21, 1971, at the untimely age of 36, Martin J. Eisenberg, M.D., died suddenly at his home in Dover. Dr. Eisenberg was an otolaryngologist and a member of our Morris County component. He held his B.S. from Lehigh and his M.D. (1960) from Chicago Medical School. He was on the staff at St. Clare's Hospital in Denville and the Dover General Hospital in Dover.

Dr. Alan O. Godfrey

A well-known Essex County gynecologist, Alan O. Godfrey, M.D., a graduate of the Medical School of the University of Vermont in 1929, died on March 11 at the age of 70. He served three hospitals in Newark—Presbyterian, Babies and the old Newark City—and the St. Barnabas Medical Center in Livingston. Dr. Godfrey was active in the New Jersey Obstetrics and Gynecology Society, in the affairs of the Essex County Medical Society, and in the New Jersey Society of Surgeons.

Dr. William Harris

William Harris, M.D., a former Vice-President of the Atlantic County Medical Society, died on March 15, at the age of 63. He won his baccalaureate degree at Dartmouth, and his M.D. came from Western Reserve, class of 1933. He was a general practitioner, identified with the Atlantic City Hospital. Because of ill health, he retired from active practice in 1968.

Dr. Florentine M. Hoffman

At the grand age of 85, Florentine M. Hoffman, M.D., died at his home in New Brunswick on February 16, 1971. In 1909 he won his medical degree at the old Long Island College Hospital in Brooklyn. He was a pioneer surgeon in the Middlesex County area, affiliated with most of the hospitals in Perth Amboy, New Brunswick, and Somerville. He was a Fellow of the American College of Surgeons.

Dr. William Landesman

Bill Landesman was one of the first residents of the Kearny-Arlington area to establish a surgical practice. He was a member of the class of 1926 at Bellevue and showed an early aptitude for surgery. He was on the staff at Newark Beth Israel Hospital, and was one of the original group to serve the West Hudson Hospital in Kearny. Born at the turn of the century, he was 71 at the time of his death on January 28, 1971.

Dr. Joseph J. Mann

At the untimely age of 40, Joseph J. Mann, M.D., died on March 7. He was graduated in 1935 from the Jefferson Medical College, and, after completing his residency in internal medicine and pulmonary diseases, he went into private practice in Ventnor. Dr. Mann became board certified in his chosen field and was on the staff of the Atlantic City Hospital. He was a member of our Atlantic County Medical Society.

Dr. Vera Schectman

One of New Jersey's earliest and best-known woman doctors, Vera Schectman, M.D., died at the age of 81, on March 1. She was a laureate of our Society's Golden Merit Award in 1962. Dr. Schectman, a 1912 alumna of the Woman's Medical College, had a special interest in gynecology and endocrinology, but always identified herself as a family doctor. She was on the staff at Newark Beth Israel Hospital.

Dr. William A. H. Scheffler

One of New Jersey's senior proctologists, William A. H. Scheffler, M.D., died on March 10. Born in Germany in 1894, he received his medical degree from Rostock University (Germany) in 1918, and came to this country soon after World War I. Before retirement he was on the staff of the Cooper Hospital in Camden, and was active in the national and New Jersey Proctology Societies. He was a 1968 recipient of the MSNJ Golden Merit Award.

Dr. Elroy W. Smith

Elroy W. Smith, M.D., who retired in 1949, died on January 20, 1971, at the age of 81. He was a urologist, a 1913 alumnus of the Long Island College Hospital, and for many decades was attending genitourinary surgeon at the Passiac General and at the St. Mary's Hospitals in Passaic. He was a member of our Passaic County Medical Society.

Dr. Michael Walkenberg

Michael Walkenberg, M.D., an internist who practiced in Newark all his professional life, died on March 5. He loved the city and was content to serve its people. Born in 1897, he received his M.D. at Temple in 1925. He was a member of the Essex County Medical Society and on the staff of Newark Beth Israel.

Dr. Abram Weiss

A heart attack in Florida took the life of Abram Weiss, M.D. of Teaneck. Born in 1900, he was an alumnus of the Medical School (class of 1921) at Tulane, one of the youngest graduates to obtain that degree. During World War II, he was a flight surgeon and when he returned to practice, he limited himself largely to general surgery and proctology. He was a fellow of the American College of Surgeons, and was active in committee work for the Bergen County Medical Society. At our 1971 Annual Meeting, he will receive the Golden Merit Award, though it will be given posthumously. Dr. Weiss died on March 1.

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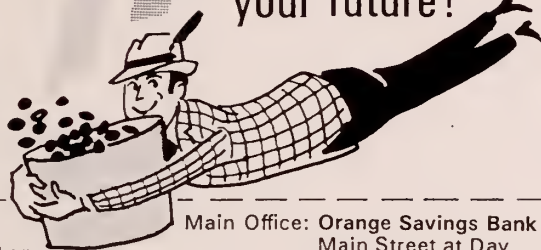
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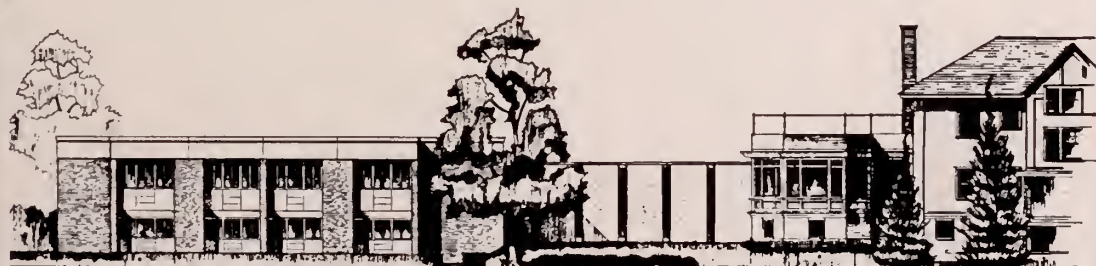
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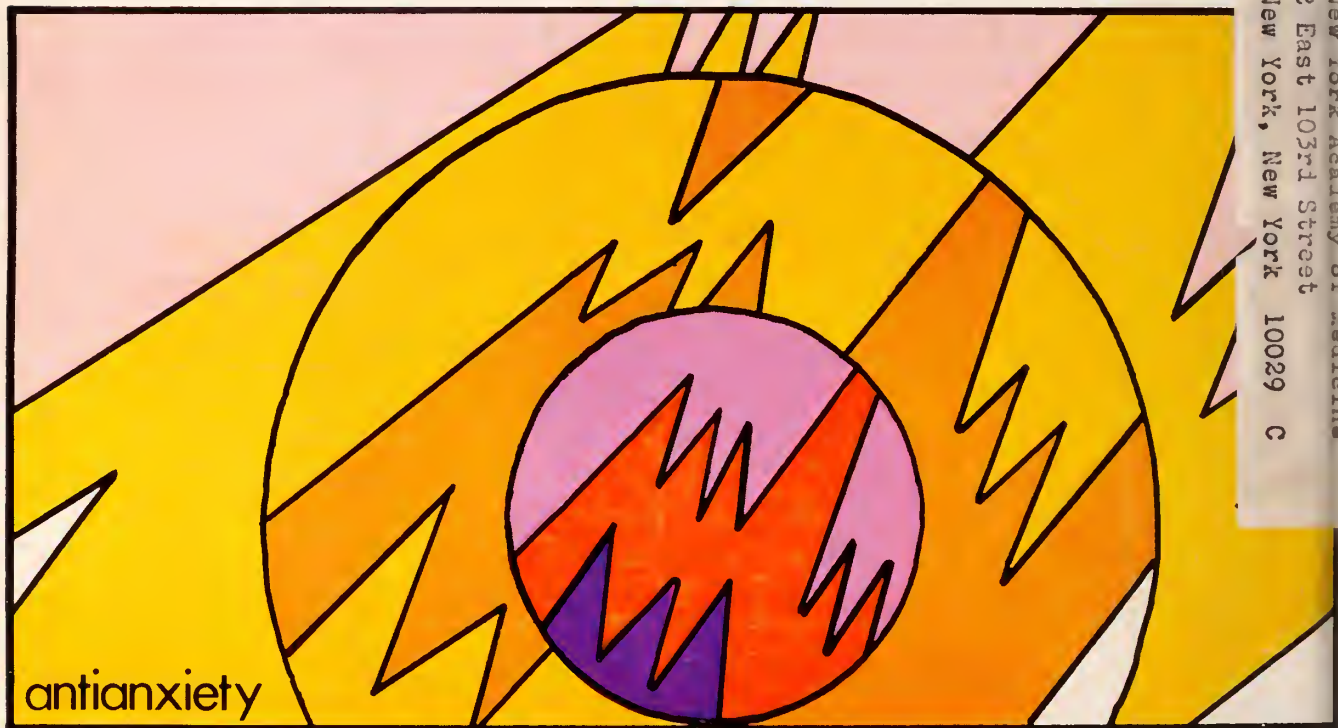
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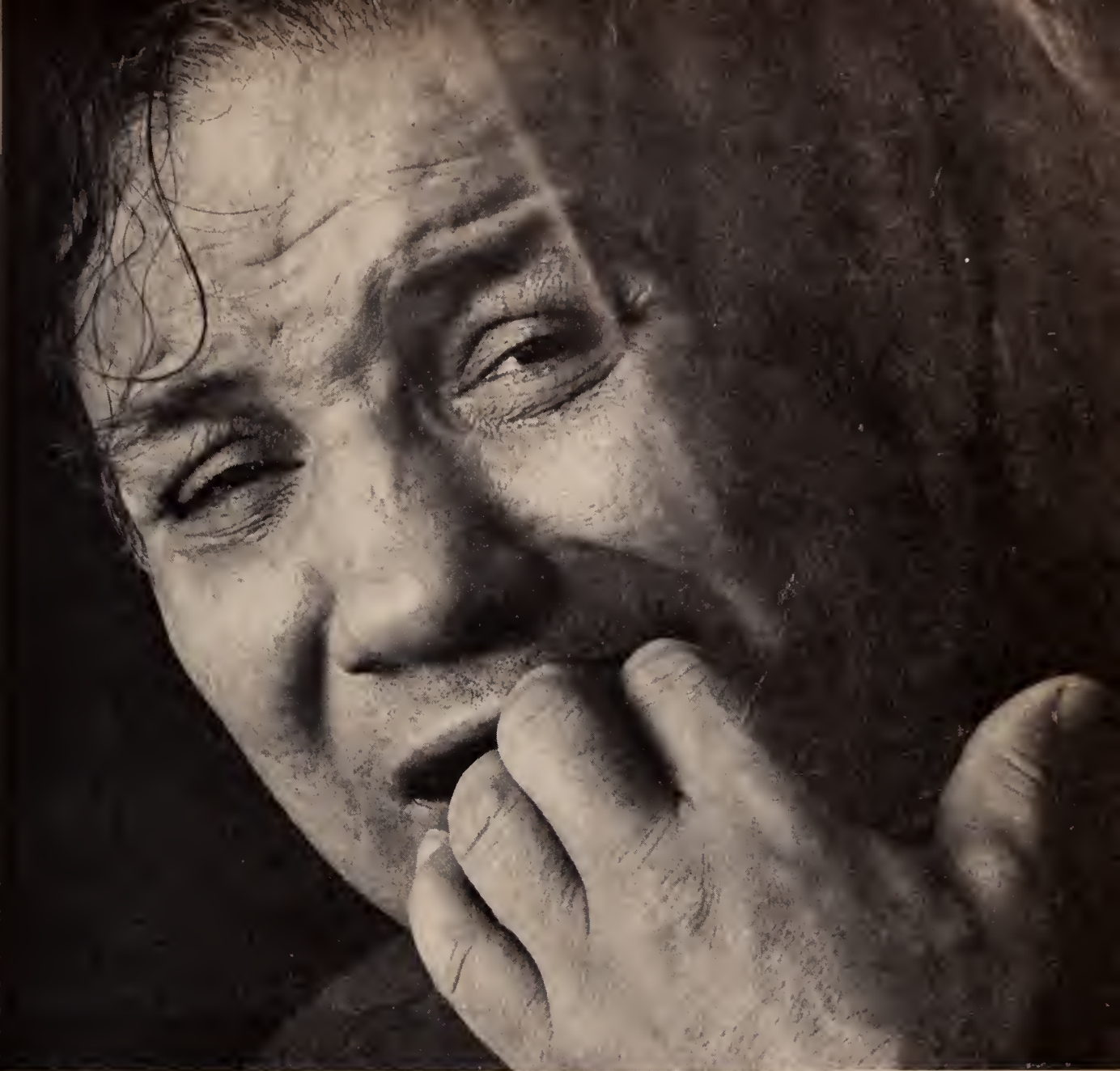
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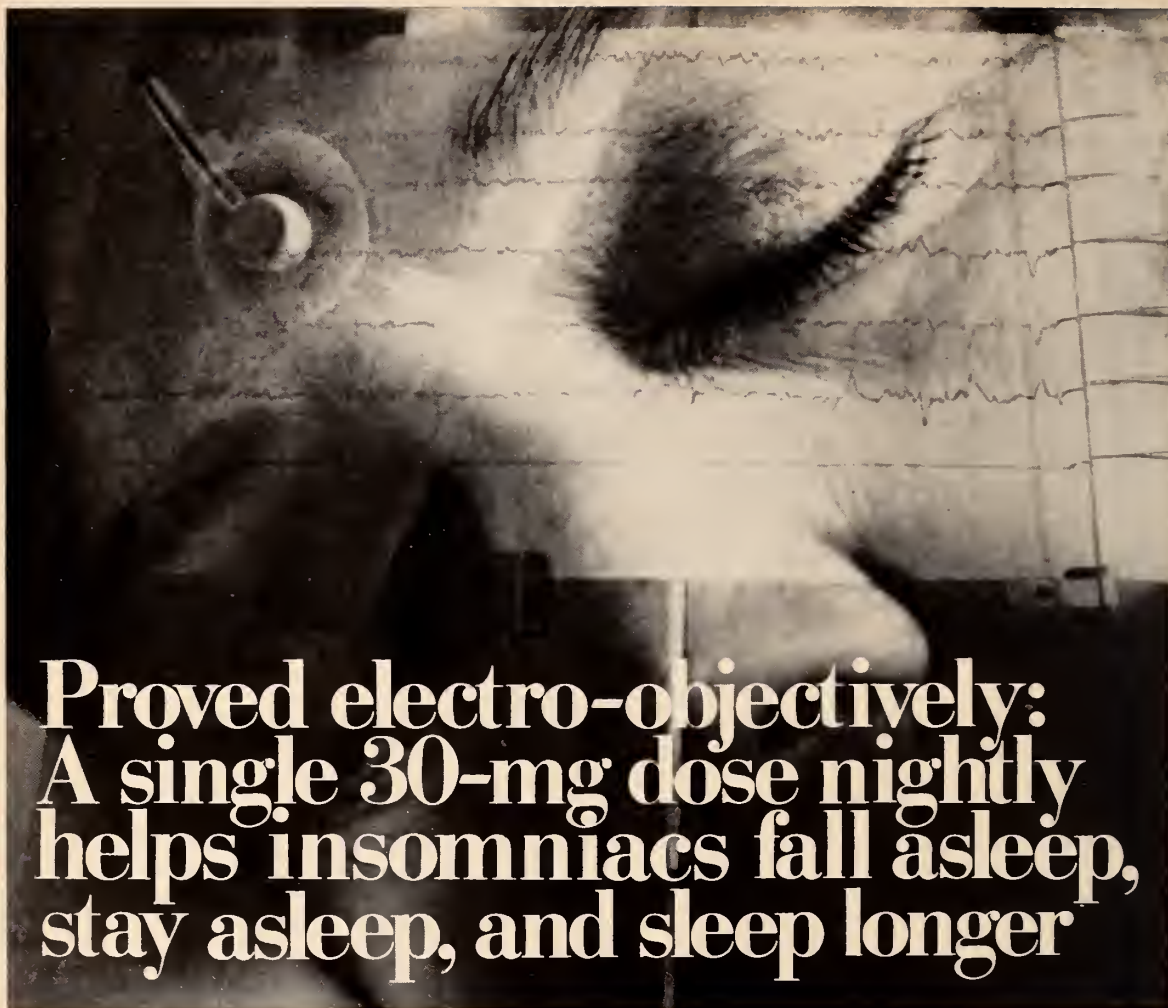
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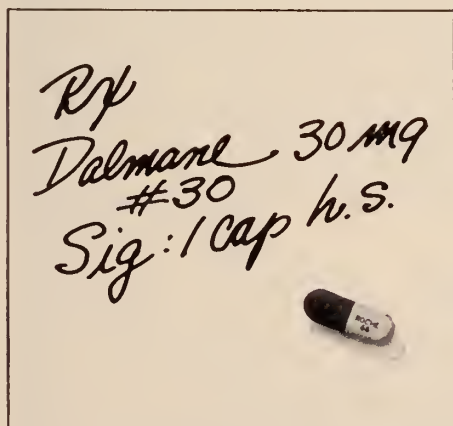
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References: 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



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Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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EDITORIALS

The New Hand At The Wheel



Most of New Jersey's population is concentrated in its northeast corner, which makes our state look like a satellite of New York City. But we have a lot of good people in southern New Jersey, too. Our convention locale—Atlantic City—stands as a kind of bridge, sharing something with Philadelphia and something with the giant metropolis to our north. So, every once in a while—perhaps not frequently enough—we need a man to remind us of the contributions that come from south of the Rancocas.

All of which is a long-winded way of introducing E. Vernon Davis, M.D., our 179th President. In 1930, he received his M.D. at the Jefferson Medical College. He then crossed the Delaware and interned at the

Cooper Hospital in Camden. He soon became interested in surgery in general and in orthopedic surgery in particular. He became a board diplomate in that field and has a number of hospital staff appointments in his chosen specialty. He is deeply involved in civic and community work. He is on the Burlington County Welfare Board, for instance, a past president of the Moorestown Rotary Club, medical director of the United Cerebral Palsy Clinic in his area, and is a voice that is listened to respectfully and effectively in a wide spectrum of such activities.

To The Medical Society of New Jersey he has made enormous contributions. He headed up the Burlington County Medical Society, and has been Chairman of our Society's Judicial Council. Of course, it was no surprise when the House of Delegates chose him to occupy the Vice-Presidential chairs, before his becoming President-Elect in 1970.

Our profession is beset by more challenges today than at any time since World War II. We know not what storms may lie ahead for us. But no matter how stormy the weather, we know we will have a firm hand at the wheel.

A Separate Department Of Mental Health

In 1918, when the Department of Institutions and Agencies was created, our Medical Society played an important role. At that time each state hospital, penal institution, and welfare agency had its own local board, but there was no statewide coordination. This, however, had already developed in most states. New Jersey finally adopted the system in 1918, but—almost uniquely—brought welfare, corrections, and hospitals into one state agency. There seemed to be a certain logic in it, since most of the patients, inmates, and beneficiaries were, in a sense, society's troubled people—or, perhaps, people in trouble for whom the state was assuming some re-

sponsibility. In these days of cutting hospital and welfare costs, it seems right to remember that one measure of a civilized community is its protectiveness toward society's unfortunates. So, in 1918, our brand new Department of Institutions and Agencies seemed like a wonderful idea—innovative, flexible, and compassionate.

More than a half century has passed since then. Nearly every state has found it necessary to carve out a state department of mental health, mental hospitals, or mental hygiene. At its 1970 session, the House of Delegates of The Medical Society of New Jersey asked the legislature to follow this lead. Specifically, by Resolution 13, our House of Delegates approved the following: "That The Medical Society of New Jersey wholly adopt the position statement of its Council on Mental Health, urging a separate department of Mental Health and Mental Retardation, with a board-certified psychiatrist as Commissioner thereof."

In New Jersey, and everywhere throughout our country, most of the hospitalized mentally ill are in public institutions by contrast with the physically ill, where most are in non-government hospitals. The state has a different and more direct concern about mental illness than a public health department is expected to have about physical illness. The peculiar and difficult needs of the hospitalized mentally ill require that a psychiatrist have direct access to the Governor. Of the five who, since 1918, have been commissioners of the Department of Institutions and Agencies, not one was a physician—yet this commissioner had to take the initiative in helping people afflicted with one of the commonest of all illnesses. It is understandable that a penologist, a psychologist, a personnel man, or a social worker would find different areas of need than a physician would.

At the request of our State, the American Psychiatric Association surveyed the mental health needs of New Jersey. Their report coincides with the recommendation of our House of Delegates.

Twice before our Society was instrumental in stimulating the establishment of state departments—the Department of Institutions and Agencies, and the Department of Health a decade later. Surely now is the time for the Medical Society to stimulate the creation of a separate Department of Mental Health and Mental Retardation.

The New Auxiliary President



Martyna Hudak McLean received her R.N. from the Pittston (Pennsylvania) Hospital School of Nursing. She met Donald McLean, M.D., while he was completing his pediatric residency. In 1948 they were married and in 1953 the McLeans moved to Salem, New Jersey. Marty joined the Auxiliary, and as their representative to the Salem County Council on Public Health Service she was a dynamic factor in the establishment of the Salem County Health Department. She still serves as chairman of its advisory council.

As President of the Salem Child Welfare and Visiting Nurse Association, Marty realized that this organization's service to the people might be greatly expanded, if it were brought under the jurisdiction of the County Health Department. During her term of office, she was instrumental in accomplishing this. Then she accepted the position of Chairman of the Health, Welfare, and Recreation Council of the United Fund, and continues to serve on its Board of Directors. Recently a new Salem County Intra-Agency Council was formed, and Marty, naturally, was named as its first chairman.

Her county auxiliary elected her twice to the Presidency and she has served at the state level as Credentials Chairman and Recording Secretary, before becoming Second Vice-President. Marty is active in St. Mary's Catholic Church, and served as President of the Parish Council in 1969. Her hobbies are bridge, bowling, golfing, reading, traveling, and helping people.

The Ultimate Physician

One of the proposed solutions to the doctor-shortage is the development of subprofessional personnel to do many of the physician's chores. A brief review of the seriously advanced proposals shows suggestions for personnel to be called clinical aides, physicians' assistants, home health aides, and so on. (Anybody remember the concept of "the farrier?") Some think that we ought to go back to the system of letting boys and girls go directly to the professional school, fresh out of high-school, and skip the intervening college years. (Some of our most prosperous chiropractors have done it that way). It has been proposed that for the students taking the by-pass, a three year medical college would be sufficient. The mini-doctor need not study Latin or medieval history, since being an intellectual would not help him in bandaging sprains or opening boils. Then, too, nurses, social workers, psychologists, and midwives could be trained to do a lot of the work the physician now does. One recently offered plan calls for

former army or navy medical corpsmen to work, either in hospitals or in physicians' offices as "assistants." With the development of an expanding corps of assistants, aides, subprofessionals, or whatever you call them, the doctor of medicine could then be just the consultant, making top-level decisions on life and death matters and leaving all other activities to the "what-d'-you-call-'em."

Already we see more signs of this. In many laboratories, for instance, all the "routine" work (strange word) is left to technicians or technologists, and the M.D. director comes in only at high level decisions. There are physicians who, in their own offices, have nurses or technicians get all the preliminary data, write up medical complaints and medical histories, take blood pressures, record laboratory findings, and prepare everything in a neat and simple package so that the busy doctor has it all predigested for him. In this situation, the person who spends least time with the patient is the doctor of medicine. Even today a radiologist or pathologist can, if he wants to, function without seeing the patient at all—just making decisions by looking at films and reports. Some internists are approaching this desideratum, too, and if skills of the peripheral observers continue to sharpen, and if we develop machines for reading electro-cardiograms, the internist may reach the state where he need not even set eyes on the patient. Then, too, it is argued that the M.D.'s great value will be in teaching the other people, so that if one physician lectures to twenty "assistants," he will handle, through these assistants, twenty different patients. This would certainly be an "efficient," time-saving method.

This suggests that, as time marches on, the M.D. will see fewer and fewer live patients, and do his good works through records, through aides, and through teaching others how to do it. And finally we will have reached the ultimate physician: the one who never sees a patient. And so it will come to pass that we will cure our troubles. But, to quote the maxim of Syrus: *graviora quaedam sunt remedia periculis*.

ORIGINAL ARTICLES

In this forward-looking address, our new President urges that we accept the challenge of change and the need for personal responsibility on the part of both doctor and patient.

Emphasizing The Basics

E. Vernon Davis, M.D./Mount Holly

This is the climactic honor of my life. It produces in me a deep sense of humility, a profound sense of gratefulness, and a prayerful spirit of hope. I am humbled by the indications of your generous confidence in me, grateful for the opportunity to serve as the head of our great and distinguished Medical Society, and hopeful that I may prove myself in action to be worthy of the office which now I assume.

You may be sure that from my very soul I shall try to do all in my power to acquit myself of my responsibilities as the 179th President of The Medical Society of New Jersey, and to follow faithfully the patterns of accomplishment of my distinguished predecessors. My commitment to whole-souled effort is the greater because of my realization of my many obligations—to the members of the Burlington County Medical Society who sponsored me, to the members of The Medical Society of New Jersey who elected me, and to the people of our State who look to us of organized medicine to be the protectors of their health and the promoters of their well-being.

So complex, diversified, and intertwined are the factors of daily life for all today that to survive and prosper together each one of us must apply himself energetically and conscientiously to the challenges of our times. It is vain to indulge the hope that by some stroke of magic the complexities and difficul-

ties that face us all will fade and pass away. It is equally vain to hope that government can readily dispose of the problems which we have all helped to produce. Only by total involvement on the part of all of us, with each doing his best to perceive and further that which will result in the broadest possible good for the greatest number, can we expect to meet and deal with the awesome challenges of our times. Selfishness will not serve, nor arrogant self-seeking. We must embrace a spirit of generous open-mindedness and goodwill—all of us. Unless we do, the likelihood is that widespread as is our present discontent and heavy as are our individual burdens, the future will produce only an increase of both. We must reason together as a people—not as separate and opposed factions—and having agreed upon reasonable goals and the means to attain them, we must work together for the continuance and stability of our American society and for the survival and increasing achievement of our country.

It is futile to yearn for the return of the "good old days." The likelihood is that they were truly such only for a relative few. We are living—as all people must—in the present. We are called upon to meet the challenges of the present to the end that we may find satisfaction in the achievements of our lives, and so that we can give those who follow after us as little handicap as possible when they take over.

All this is really not new. Our era calls for

and produces changes just as every other era in the history of man has done and will continue to do.

Our own illustrious David B. Allman, whose recent death we mourn, in a speech which he delivered more than a decade and a half ago declared: ". . . I am convinced that the determining factor for survival—as for success—is the ability to adjust to the changing conditions of life, and to overcome them, rather than be overcome by them.

"The challenge of life, it seems to me, is change—change which is fraught with peril for those who cannot meet it, but is merely a prologue to new triumph for those who are sufficiently adaptable and resilient to adjust to it.

"There can be no growth without change, as there can be no decay. There can be no standing still, either. Change is inseparable from life, and its reverberations seem palely to carry even beyond the frontiers of death. So, we must acknowledge the constancy of change, confront each new change as it comes along, and bend our energies to meeting and controlling it. That is our challenge as members of society, and it is no less our challenge as members of the profession of medicine."

I say a fervent "Amen" to that discerning comment. I offer it to you as sage advice.

I shall not comment at this time on the changes that confront all of us as members of society today, except to say that they seem to permeate and involve every area of human action and every level of society. But let us consider, briefly, the calls for change that we must face up to as members of the medical profession. Basically the thrust is to make quality medical care equally available to all, not only when they are ill but when they are well, to prevent them from falling ill. To eliminate inability to pay as a deterrent to this availability, third party plans of many kinds, both private and governmental, are being used and their expansion urged.

It seems to me, there is one tremendous handicap that confronts the medical profession in consequence of the increased demand for services; that is the lack of medical and allied manpower. That is why Congress is being properly urged to take steps effectively to alleviate shortages of medical manpower and facilities before enacting legislation that will impose massive new demands on the health care delivery system. The fact is that most pending legislation is intended mainly to give people more money, directly or indirectly, with which to buy health care. The movement disregards the simple truth that you cannot purchase what is not there to be sold.

I am disturbed by the acrimony that centers around the costs of health care today, but I think if we are sincere in our purpose to make health care services available equally to all, it is of primary importance that steps be taken to increase the supply—and hence the availability—of the so-called deliverers of health services. Most of the nation's 103 medical schools are financially hard-pressed. It is absurd to ask them to expand their facilities, enlarge their classes, concentrate their curricula, and turn out vastly greater numbers of graduates, when they have not the means of carrying on even in their present circumstances!

We not only need more doctors but we need more, many more, of all the allied personnel who assist physicians in the care and treatment of patients. This, I think, should have first priority as a national need. I ask you to join me in urging that this primary need be recognized and dealt with—promptly.

We have an intensified need for an influx of new personnel in the field of the delivery of health services, not only because more people are clamoring for health care services but because the physician is simultaneously being urged to pursue regular programs in graduate education, take part in peer review operations of all kinds, and participate actively in community affairs. We must, I think, always remember to put first things first, and a physi-

cian's first and most important responsibility is to take care of his patients. If he cannot do that, whatever else he does is relatively unimportant.

Just as it is the physician's basic job to take care of his patient's health, so it is also the patient's personal responsibility.

I was encouraged to read a comment bearing upon this recently. John J. Millis, Ph.D., writing in the *New England Journal of Medicine*, said:

"Far too many people regard health as being 'doctored.' They therefore hope that with the right to unlimited access to physicians and hospitals, they will all be healthy. Surely 'doctoring' is a necessary element in health, but it is not sufficient. The provision of health service to all citizens will result in some improvement in our national figures on morbidity and mortality. However, that improvement may be disappointingly small. There are large contributors to morbidity and mortality about which physicians and hospitals can do little. Accidents are the greatest cause of both morbidity and mortality for Americans between the ages of 1 and 37 years. Other important causes for all age groups are obesity, smoking, abuse of alcohol and other drugs, environmental pollution, and a life style that leads to psychosomatic disease. With the exception of environmental pollution, there is very little that society can do to control these causes except through intolerable restrictions on personal liberty. The control can come only through the behavior of the individual. Only his decisions and his actions can eliminate these causes of disability and death.

"My conclusion is that we accept the concept that health is a necessity but realize that we as a society, can guarantee only access to health service. Personal health must remain a personal responsibility. Thus, as we work to provide for more health professionals and a more efficient system for the delivery of their service, we must also convince people that the achievement of health demands responsibility and action on the part of each individual."

And in those thoughts I heartily concur.

As members of The Medical Society of New Jersey we are dedicated to the service of mankind. No service is more demanding, more challenging, or more important. It is in that service, in the best and highest tradition of our profession, that I urge you to persevere. There are many ills to be dealt with and we of medicine are in position to make a tremendous contribution to the general good. As I said earlier in this address, "Only by total involvement on the part of all of us, with each doing his best to perceive and further that which will result in the broadest possible good for the greatest number, can we expect to meet and deal with the awesome challenges of our times."

To that total involvement, I pledge myself. It will be an honor to be working with all of you.

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Now available is a guide to visual factors in safe auto driving. This will help physicians determine whether their patients' visual problems may limit their driving proficiency. Developed by the AMA Committee on Medical Aspects of Automotive Safety, with assistance from the American Committee on Optics, the guide subdivides drivers as to the degree of responsibility and risk while operating an automobile.

The categories are: Class I—Professional drivers operating large passenger-carrying vehicles; Class II—Commercial taxi drivers

and professional drivers operating large non-passenger-carrying vehicles, and Class III—Operators of private vehicles.

The provisional standards cover the determination of central visual acuity, field of vision, color vision, associated ocular pathology, post-operative aphakia, and visual function affecting night-time driving.

You, as a physician, may get a copy of the guide from the Committee on Automotive Safety at the AMA headquarters, 535 North Dearborn Street, Chicago, Illinois 60610



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Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous

eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . . 500 mg.

*References available on request.

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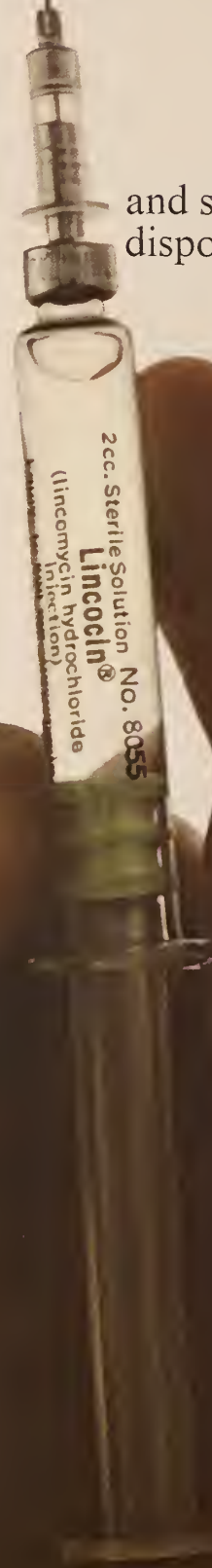
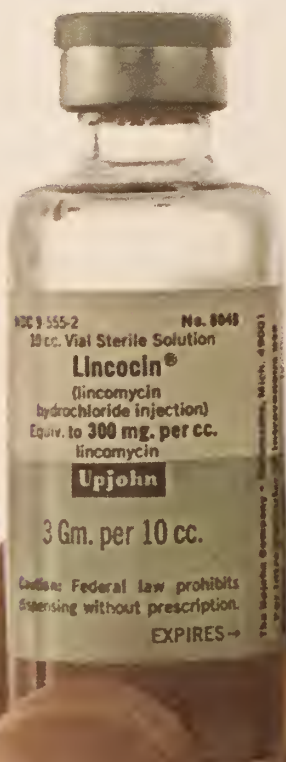
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In managing post-infarction ventricular arrhythmias, drug therapy remains the backbone of treatment.

Treatment Of Late, Post-Myocardial Infarction Ventricular Arrhythmias

**Michael A. Nevins, M.D. and
Leonard J. Lyon, M.D./Paramus***

Persistent or late-appearing ventricular premature systoles (VPC) or ventricular tachyarrhythmias are frequent complications of healed myocardial infarction.

Unsuspected ventricular arrhythmias have been observed¹ in 75 per cent of patients recovering from acute myocardial infarction who were monitored on the day prior to their hospital discharge. Late deaths in patients who have survived acute myocardial infarction are usually not due to new thrombotic events, but to sudden derangements of cardiac rhythm, particularly ventricular fibrillation.² Evidence suggests³ that ventricular irritability is a poor prognostic sign in patients with coronary artery disease. Even in apparently healthy middle-aged men, the finding of ten or more VPC per 1,000 heart beats is associated⁴ with a tenfold increase in the incidence of sudden death. Ectopic ventricular rhythms must be considered a serious risk factor in patients with previous myocardial infarction.

It has not been established whether *all* post myocardial infarction patients should receive antiarrhythmic therapy or whether those displaying ventricular irritability should be managed differently from non-coronary patients with similar rhythm disturbances. No reported study convincingly demonstrates that prolonged antiarrhythmic therapy,

(whether given to random or selected patients) increases late survival after myocardial infarction. Of course, there are varying degrees of risk, so that the presence of a rare VPC is of doubtful significance while, as with acute myocardial infarction, frequent VPC that are multifocal, repetitive, or of short coupling interval are of greater importance. The potential added risk conferred by these complex arrhythmias justifies the expense and possible morbidity of chronic suppressive therapy.

Despite the magnitude of the problem and the many available forms of antiarrhythmic therapy, there are no clear guidelines for their use in this clinical setting nor criteria of adequate control. We will here review the various therapeutic modalities and offer an approach to the treatment of these potentially lethal, often difficult to manage, post-infarction ventricular arrhythmias.

When ventricular irritability is detected in a post-infarction patient, underlying factors should be sought and corrected before suppressive therapy is initiated. Among these remediable problems are the following:

1. *Congestive heart failure*—Late appearance of cardiac decompensation after myocardial infarction suggests a ventricular aneurysm or other asynergic muscle disorder. Even occult congestive failure may be associated with arrhythmias that disappear with improvement in myocardial function.

*The authors are co-directors of Medical Education, Bergen Pines Hospital, Paramus, New Jersey.

2. *Electrolyte and acid-base disorders*—Hypokalemia is a well-recognized cause of arrhythmias. Less frequently considered is hypomagnesemia which may also complicate diuretic therapy, and which has been implicated⁵ on occasion as the etiology of otherwise unexplained ventricular arrhythmias. Hypomagnesemia should be suspected in cases of obscure arrhythmias, particularly those associated with QT prolongation but normal serum calcium and potassium levels. Magnesium deficiency may lead to loss of intracellular potassium resulting in prolonged and asynchronous repolarization of myocardial cells, a situation which greatly predisposes to the development of ectopic rhythms.

Hypoxia and acid-base derangements should be sought for utilizing arterial blood gases in patients who are elderly or have chronic lung disease, and treatment instituted, if necessary, to improve ventilation and oxygenation.

3. *Drug toxicity*—Iatrogenic arrhythmias should be suspected when ventricular irritability appears in a patient receiving digitalis, quinidine, clofibrate⁶ or large doses of thioridazine.⁷ Naturally, the suspected drug must be eliminated from the patients regimen before antiarrhythmic therapy is instituted.

Principles of Drug Therapy

After contributing factors to ventricular irritability have been corrected, medical management begins by systematically using one drug at a time and persevering until intolerable or dangerous side effects are encountered. Confusion arises when drugs are discontinued because of minor side effects that may be transient or may be controlled with supplementary medications. Adhering to an arbitrary upper limit of dose is inadvisable since certain patients require and can tolerate large amounts of drug.

Drug therapy of ventricular arrhythmias should be initiated with procainamide or quinidine. Although the mechanisms of action of these drugs are similar, patients who are refractory to large doses of one, sometimes respond to modest doses of the other. When one of these appears ineffective, the other should be tried. It is not unusual for patients to require four to six Grams of procainamide daily and doses in excess of 10 Grams have been reported.⁸ Procainamide's optimal effect is quickly dissipated. The timing of quinidine therapy is also related to its therapeutic effect. For example, the six hourly schedule commonly employed requires three to five days to achieve a maximum plasma level. Timidity in determination of maximum dose leads to a false impression of "re-

fractoriness" and unnecessary or premature changes of medications. When available, plasma assays are valuable in confirming satisfactory concentrations and ambulatory monitoring is useful to test drug efficacy.

Quinidine and procainamide have negative inotropic effects when used in larger doses and may aggravate congestive failure. Both may slow ventricular repolarization or cause hypotension and thereby contribute to enhanced ventricular irritability. Although both drugs can cause dangerous brady- and tachyarrhythmias when given in excessive dosage, certain complications of quinidine therapy are due to individual sensitivity and are unrelated to the duration or magnitude of treatment. These include thrombocytopenic purpura, hemolytic anemia, and paroxysmal ventricular tachycardia and fibrillation ("quinidine syncope"). On the other hand, the occurrence of serologic signs and symptoms of systemic lupus erythematosus in patients receiving procainamide seems clearly related to dose and duration of therapy. Serologic abnormalities were found⁹ in 77 per cent of a group of patients receiving procainamide and in 92 per cent of those whose dose exceeded 1.2 Grams daily. Abnormal serologic reactions are not always followed by the appearance of clinical symptoms. The symptoms themselves are usually mild and disappear soon after procainamide is discontinued. We do not, therefore, feel that the demonstration of antinuclear antibodies or a positive lupus erythematosus preparation precludes continued therapy when ventricular arrhythmias persist.

If procainamide and quinidine are ineffective, the following drugs should be considered:

1. *Digitalis*—A trial of digitalis is indicated even when congestive heart failure is not evident. Gratifying results have been obtained, particularly in the presence of myocardial contractile disorders where sub-clinical congestive failure may contribute to the genesis of arrhythmias.

2. *Diphenylhydantoin*—Chronic suppression of ectopic foci with this drug is complicated by a high incidence of side effects that may require withdrawal (18 per cent in one series).¹⁰ Diphenylhydantoin is most effective for digitalis-toxic rhythms, and its properties of

speeding atrioventricular and intraventricular conduction with minimal negative hemodynamic effects are useful in selected patients.

3. *Propranolol*—Beta-adrenergic blocking drugs should be used cautiously in the presence of congestive heart failure or conduction disturbances. However, in the treatment of angina pectoris, doses two to three times greater than those required for antiarrhythmic effect are usually well tolerated even by patients with compensated congestive heart failure. Only severe or refractory congestive failure absolutely contraindicates the use of beta-blockade. Dosage must be individualized, since a fixed oral dose can result in a sevenfold variation in plasma levels.¹¹

4. *Bretylium*—This antihypertensive drug is finding new application as an antiarrhythmic agent. A recent paper¹² described the successful use of oral bretylium in a patient with recurrent ventricular tachycardia refractory to other drugs and rapid pacing.

5. *Drug combinations*—When standard antiarrhythmic drugs have been unsuccessful singly, combinations may be tailored to the patient's needs. Digitalis is useful to counteract the negative inotropic effects of other antiarrhythmic drugs and it has been suggested¹³ that digitalis can be tried in larger doses with less likelihood of toxic arrhythmias if diphenylhydantoin is used concomitantly. Diphenylhydantoin might also be added to procainamide or quinidine when these drugs cause prolonged QT intervals. Quinidine and propranolol are reported¹⁴ to have synergistic effects and control has been achieved with their combined use when individually they have failed.

Occasionally, ventricular arrhythmias persist despite large doses, singly and in combination. This causes a therapeutic dilemma in which the risk of sudden death must be balanced against the hazards of more involved treatments such as rapid pacing and cardiac surgery. Social, emotional, and economic factors take on added significance at this time. Patient tolerance of arrhythmias and presence of high risk factors, such as premature systoles which are multifocal, interrupt the T wave, or occur in salvos or runs, are determinants of whether absolute or relative control is necessary. If it is decided not to proceed with further treatment, vigilant surveillance (preferably with ambulatory monitoring) is indicated. Deterioration of clinical status despite full medical therapy dictates a more aggressive approach, often preceded by angiographic evaluation of myocardial function and coronary arteriography.

Pacing

When complete heart block is present, suppression of recurrent arrhythmias can generally be achieved by pacing at rates of 70 to 80 per minute. In the absence of AV block (or

bradycardia), pacing rates in excess of 100 are usually required. Many patients in whom overdriving has been successful have not had underlying ischemic heart disease. Patients with severely diseased coronary arteries may have significant impairment of coronary perfusion at rapid rates. Long term experience with this is limited since most of the patients reported recovered or died after a period of temporary pacing. Overdriving is not always effective. If the rate is progressively increased in an effort to suppress ectopic foci, angina, congestive heart failure, or arrhythmias may ensue. We¹⁵ have described a patient with a previous myocardial infarction, ventricular aneurysm, and recurrent ventricular tachyarrhythmias in whom increasing the pacing rate to 150 per minute caused more frequent episodes of ventricular fibrillation that dramatically ceased when pacing was discontinued. Rapid artificial pacing may sometimes aggravate, rather than suppress ventricular irritability. Nonetheless, it is the simplest nonmedical treatment and is a logical second step when drug therapy alone is ineffective in preventing serious recurrent ventricular arrhythmias. Pacing can often be combined with antiarrhythmic drugs to establish control at slower, more tolerable pacing rates.

When essential drugs (digitalis, procainamide, quinidine, propranolol) cause atrioventricular block or dangerous sinus bradycardia, pacing ensures a satisfactory ventricular rate so the antiarrhythmic drugs can be continued in effective dosage. The combination of pacing and antiarrhythmic drugs is also useful when there are alternating slow and fast rhythms ("bradycardia-tachycardia syndrome"). Temporary control of ventricular arrhythmias can be accomplished by producing a sinus tachycardia with atropine and isoproterenol in those instances when atrioventricular conduction is intact and artificial pacing cannot be immediately instituted. The technic is also used as a therapeutic trial to determine whether ectopic foci can be abolished by rate acceleration.¹⁶

Rapid pacing (like antiarrhythmic drugs) suppresses ventricular irritability, but has no

beneficial effect on the underlying heart disease. Atrial pacing (when atrioventricular conduction is normal) or sequential atrioventricular pacing (in the presence of atrioventricular block) is hemodynamically superior to ventricular pacing in most instances, but ventricular pacing is usually tried because it is the simplest and most dependable transvenous pacing technic. Some patients with recurrent ventricular arrhythmias (particularly those whose arrhythmias first appeared at the time of an acute myocardial infarction) can be weaned off the pacemaker after weeks or months of treatment and maintained on drugs alone. Therefore, permanent pacing should always be preceded by a prolonged period of temporary pacing, not only to ascertain efficacy and optimal pacing rate, but also to allow for the possibility of spontaneous improvement.

Surgery

In 1953¹⁷ Bailey performed an aneurysmectomy to treat refractory ventricular tachycardia unassociated with congestive heart failure. Recent reports have renewed interest in this procedure, although one case was apparently described in three different journals^{18, 19, 20} giving a false impression of the frequency and success of surgical treatment of these arrhythmias. Reports²¹ of large series of patients with ventricular aneurysms indicate that recurrent ventricular tachycardia is an infrequent complication. In those patients with ventricular irritability who have undergone aneurysmectomy primarily because of congestive heart failure, arrhythmia control has

not always paralleled hemodynamic improvement. It remains to be seen whether resection of aneurysms or asynergic areas will prove safe and efficacious for the long-term control of arrhythmias. At present the procedure should be reserved for the most desperate situations. Aneurysmectomy has been successfully done on apparently moribund patients in cardiogenic shock, and in one instance²² with recurrent ventricular fibrillation.

Myocardial revascularization may be used as an adjunct to definitive resection of an asynergic area, but its physiologic benefits could not be anticipated for several months. Aortic-coronary anastomosis by vein graft has the theoretic advantage of immediate improvement in coronary blood supply. However, this approach has not yet been reported as a treatment for ventricular arrhythmias.

Conclusion

Drug therapy remains the keystone in the management of late, post-infarction ventricular arrhythmias. Suppressive therapy should be liberally used even in asymptomatic patients with significant rhythm disturbance in an attempt to reduce the likelihood of sudden death. Drug therapy should be applied systematically, with each drug in turn given in a maximal dose before a change in therapy is considered. Only patients truly refractory to medical management should be considered for other therapeutic modalities such as pacemaker over-driving or cardiac surgery.

A bibliography of 22 citations is available from the author upon request.

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Marriage And Love In The Middle Years

J. A. Peterson, Past-President of the American Association of Marriage Counselors, has written a 28-page booklet entitled, *Marriage and Love in the Middle Years*. This is a sensitive discussion of what can be the most impoverishing and frustrating epoch in life—but what

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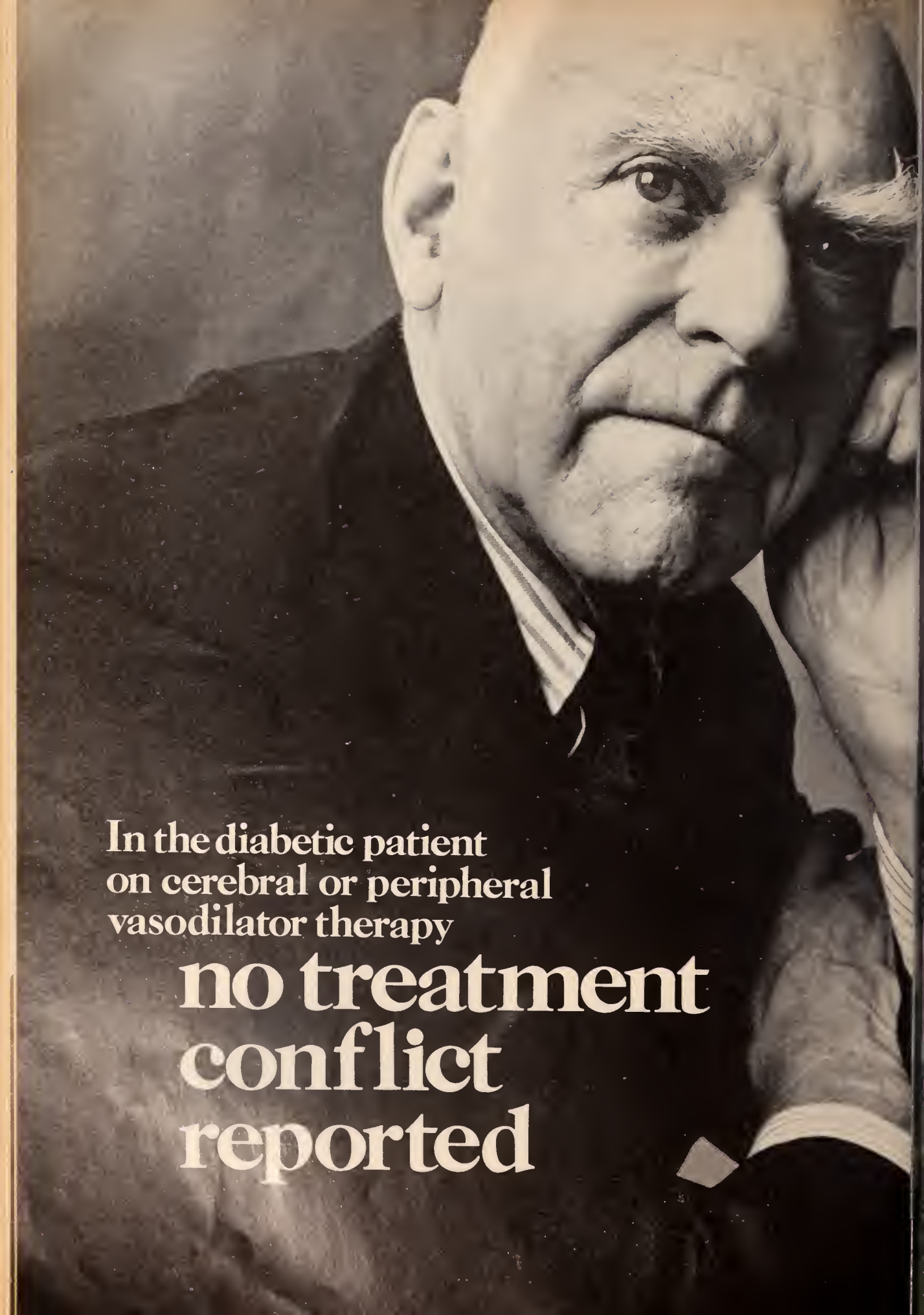


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Alcoholic Myopathy*

René DeCeuninck, M.D./New Brunswick

Of all our tissues, the brain is the one most vulnerable to the effects of alcohol. Abnormalities are also observed in other tissues in severe alcoholic intoxication, particularly in the liver and heart. The mitochondria of the heart muscle seems to be particularly affected, and this points to a serious disturbance in oxidative metabolism and energy production for contraction. Chronic alcohol consumption may ultimately result in congestive heart failure. In acute alcoholic myopathy, the patient may have generalized muscle cramps. In some instances¹ destruction of muscle tissue may be sufficient to produce gross myoglobinuria. There may be paralysis of involved muscles with loss of tendon reflexes.

Usually acute alcoholic myopathy is reversible, but in severe forms it may be followed by diffuse muscle atrophy and permanent weakness. With recurrent attacks the picture becomes transformed into that of a chronic myopathy with proximal and diffuse muscle tenderness. The combination of muscle cramps and diminished response of lactic acid to ischemic exercise closely resembles the features of McArdle's syndrome² of hereditary phosphorylase deficiency.

In acutely ill patients, even in alcoholics without muscular complaint, the serum creatine phosphokinase (CPK) levels may be distinctly elevated. The enzyme levels are also somewhat increased in the chronic form. Other enzymes (e. g., transaminases and aldolases) are similarly increased and there may be increased creatinuria. Abnormalities may be recognizable by electromyography and an abnormal ischemic exercise test.³

Histologic examination discloses well-defined lesions in alcoholic myopathy. Light microscopy, particularly when there is gross myoglobinuria, reveals fiber swelling, loss of striations, and separation of myofibrils by clear cytoplasm. In the chronic form of alcoholic myopathy the muscle fibers are varied in size and some groups of unusually small fibers occur.

Electron microscopy shows destruction, fragmentation, and condensation of myofilaments. The normal architecture of the muscle fiber is deranged as a result of destruction of I and A bands. In the chronic form there are signs of previous destruction⁴ with regeneration phenomena and atrophy, but surprising lack of fibrosis.

In one case⁵ in which there was skeletal muscle necrosis, the patient developed acute myocardial infarction, which suggests that an acute form of alcoholic cardiomyopathy may also occur.

In the following case the presence of alcoholic myopathy was clearly defined clinically:

A 52 year old man had sudden onset of weakness of both lower extremities. He had been addicted to alcohol in varying severity for the past 20 years. He had been living alone. His wife had left him two years previously. He was a heavy smoker as well as a heavy drinker. In the past he had had pulmonary tuberculosis, discovered at the age of 30. He had been treated for 15 months in a sanitarium. He developed high blood pressure. In the two years before admission he had two attacks of transient cerebral ischemia affecting chiefly the left side of his body. According to his story he had been working as usual until New Year's Eve, and then stopped to celebrate. On the following morning he was unable to stand because of extreme weakness in his legs. He fell to the ground and was unable to raise himself.

*From the Middlesex General Hospital, New Brunswick, New Jersey, where Dr. DeCeuninck was a Medical Resident.

On admission to the hospital he seemed slightly dehydrated. Coarse rales were heard throughout the lungs. The heart seemed normal except for a soft systolic murmur along the left border of the sternum. The liver was palpable four finger breadths below the costal margin and was firm. There were no spider nevi. He had marked tremor of the hands and severe weakness of both arms and both legs, affecting chiefly the proximal muscle groups. He was unable to lift his legs from the bed, was unable to stand, and unable to stretch his arms above his head. He could move his fingers and hands and feet. Tendon reflexes were largely inactive. There was questionable dorsiflexion response of the great toe.

Laboratory examinations revealed slight proteinuria. Hemoglobin and white count were normal but platelets were reduced to 118,000. The blood chemical screening revealed reduced serum albumin (2.4 Grams per cent) and some increase in total bilirubin (2.3 milligrams per cent) the direct reacting bilirubin being 1.9 milligrams per cent. Serum enzymes were elevated; SGO transaminase 590; SGP transaminase 110; LDH 260, and CPK 480. Serum amylase was 149. Blood urea nitrogen was 9; cholesterol, 120; sugar, 101; serum calcium, 7.9 milligrams per cent.

Despite administration of intravenous fluids and sedation the patient became increasingly restless and agitated. On the sixth day after admission he was overtly disoriented. His temperature ranged between 99.5 and 103. He had diarrhea and developed increasing jaundice. After administration of neomycin (orally), potassium salts, and thiamine he began to improve and within 48 hours became once again alert, responsive and tranquil, and was able to take food. However, muscle weakness persisted in both lower extremities, especially in the proximal group of muscles and pelvic girdle muscles. These now revealed evidences of severe wasting with paresis and loss of reflexes. Biopsy of the gastrocnemius revealed areas of waxy degeneration, loss of muscle fibers, and condensation of sarcolemmal nuclei. Examination of the urine at this stage revealed no evidence of myoglobin.

The patient progressed slowly, aided by physiotherapy and multivitamin therapy, and he was eventually transferred to a rehabilitation center.

Evidences of acute alcoholic myopathy were fairly easy to recognize clinically. The patient had evidences also of cirrhosis of the liver and chronic bronchitis. Although most patients with alcoholic myopathy make a complete recovery in three to six weeks, this patient appears to have suffered a more severe form of the disease and the ultimate prognosis is still uncertain.

Here is an acute alcoholic myopathy in a chronic alcoholic, manifested clinically by sudden profound weakness in all four extremities and elevation in serum enzymes. Diagnosis was confirmed by muscle biopsy.

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Patients With Intestinal Malabsorption

Your cooperation is requested in the referral of patients with known or suspected intestinal malabsorption to the National Institute of Arthritis and Metabolic Diseases. This is at the Clinical Center, National Institutes of Health, Bethesda, Maryland. The service is interested in patients with such problems as local intestinal immune response in gluten-sensitive celiac and intestinal malabsorption associated with agammaglobulinemia and related disorders. Also, Whipple's disease is under continuing study. The center will wel-

come patients with intestinal malabsorption of undiagnosed cause.

Upon completion of their studies, patients will be returned to your care and you will receive a summary of findings.

In making referrals, please mention the malabsorption project. Communicate with Saul G. Agus, M.D. at the Clinical Center, Room 9-D-15, National Institutes of Health, Bethesda, Maryland 20014.

A diagnosis, unknown a dozen years ago, is now being made with increasing frequency following more careful studies.

Intestinal Lymphangiectasia

**Charles R. Ream, M.D. and
Rodolfo C. Ouano, M.D./Elizabeth***

The diagnosis of "idiopathic hypoproteinemia" is being made less frequently because clinicians are now able to pinpoint specific disease entities that account for the hypoproteinemia state. Most cases of low protein states are *not* caused by poor protein synthesis. In 1957, Schwartz and Thomsen¹ showed a greatly increased catabolism of albumin and suggested that the disease be called "hypercatabolic hypoproteinemia." Gordon² investigated a group of patients fitting the criteria for "hypercatabolic hypoproteinemia" by intravenously injecting I-131 labeled polyvinylpyrrolidone. The fecal content of this material was measured and demonstrated an increased loss through the intestinal mucosa. He concluded that these patients lost albumin via the intestinal mucosa and termed this condition "exudative enteropathy."

Waldman, *et al.*³ further elucidated on the role of the gastrointestinal tract in idiopathic hypoproteinemia. They reported 12 cases in which the protein-losing gastroenteropathy was shown to have abnormalities of the lymphatic system. They coined the term "intestinal lymphangiectasia" and described the abnormality as dilation of the lymphatic channels in the mucosa and mesentery of the small bowel.

Case Report

A twenty-three year old woman was admitted because of a laceration of the right eyebrow and a suspicion of a cerebral concussion.

Ten years previously a diagnosis of bronchial asthma had been made and she experienced variable relief of symptoms following the use of bronchodilators, antibiotics, and hydration. The asthmatic attacks were

accompanied by infections. A year later, she had a left external otitis media which cleared quickly with topical antibiotic. Five years before admission she developed unilateral edema involving the left lower extremity with no evidence of phlebitis. She had been on intermittent dosages of diuretics over the past five years.

A year ago, she was admitted to another hospital where a diagnosis of intestinal lymphangiectasia was made following a small bowel biopsy and I-131 labeled serum albumin turnover studies. A lymphangiogram was reported as negative. Studies to demonstrate fat and/or carbohydrate malabsorption were negative. BSP injection and serial determinations (rather than a single forty-five minute specimen) showed a rapid disappearance of the dye from the plasma, and at twenty minutes no dye was observed. The study was repeated after 12.5 Grams of human albumin injection. The rate of disappearance of the dye slowed down so that at twenty minutes 2.5 per cent of the dose was still circulating in the plasma. Her liver function tests were normal. Stool collections for fat and indole products showed no abnormalities. She remained relatively well after discharge.

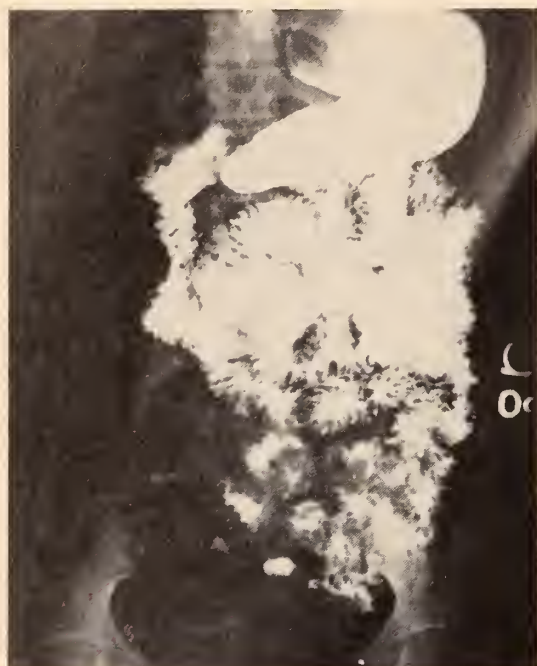
A week prior to entry to Saint Elizabeth Hospital she noted crampy pain over the left leg, numbness with tingling of the fingers and tightening of the muscles of the face. At that time, pertinent physical examination disclosed a poorly developed, malnourished female in no acute distress. A laceration was noted over the right supra-orbit. Chvostek's sign was negative. The liver was palpable 3 centimeters below the right costal margin. No flank tenderness or peripheral edema was elicited. The rest of the findings were within normal limits.

The hematocrit was 35 millimeters, the hemoglobin was 11.5 Grams per cent, and the white blood cell count was 6,400 with 75 polymorphonuclears, 22 lymphocytes, two monocytes, and one eosinophil. Serum calcium was 6.7, phosphorus, 3.5, cholesterol, 125, total protein, 3.4 and the SGOT was 58 I.U., SGPT was 62, the LDH, 230 I.U., FBS, 90, and BUN, 8. D-xylose absorption test revealed a 0.32 Gram excretion after five hours following a dose of 12.5 Gram of D-xylose. BSP showed 1.5 per cent dye retention after forty-five minutes.

The small bowel series revealed nodularity and thickening of the mucosal folds of the jejunum and ileum. (Figures 1A and 1B). Barium enema and proctosigmoidoscopy were negative.

On the eleventh hospital day, a peroral small bowel biopsy was done using the Crosby capsule. This dis-

*Dr. Ream is Physician-in-Chief to the Saint Elizabeth Hospital, Elizabeth, New Jersey, and Dr. Ouano is Chief Resident.



Figures 1A

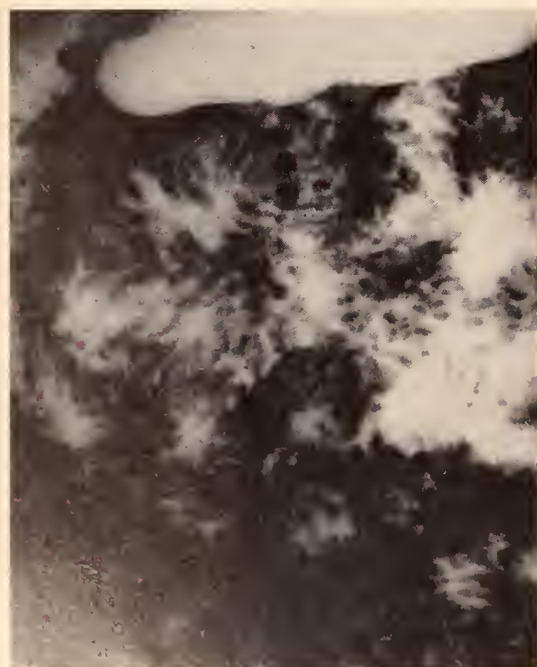


Figure 1B

flow; marked dilation of the lymphatic channels with submucosal and mucosal edema. (Figure 2). A liver biopsy the following day showed non-specific cytoplasmic ballooning of the hepatocytes with no fatty changes. The patient remained asymptomatic throughout her hospital stay. She was discharged on the 14th hospital day.

The etiology of intestinal lymphangiectasia is unknown. A congenital malformation has been proposed and a familial history of unexplained edema may at times be elicited. De Sousa, *et al.*⁴ suggested an association of nephrotic syndrome with intestinal lymphangiectasia in children and concluded that, in at least some nephrotic children, intestinal lymphangiectasia is responsible for an associated protein-losing enteropathy. This is primarily a disease of the young, with the age of onset in the reported cases being infancy to 30 years of age.⁵

In a third of the cases, onset is before 10 years of age. The major clinical manifestations are edema and diarrhea. The edema may be intermittent and unilateral, such as seen in this case. More commonly, however, it is symmetrical. In more severe cases chylous effusion into the peritoneal, pleural spaces (or both) is seen. Carbohydrate malabsorption is suggested in this case with the abnormal D-xylose test. Malabsorption is not a prominent feature in the reported cases but may occur. Our patient showed a tendency toward spontaneous fluctuations in the severity of the disease. This is not infrequent and

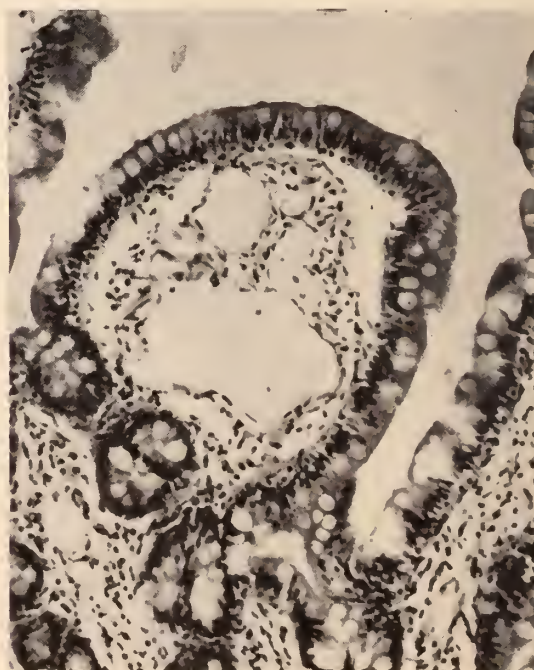


Figure 2

this feature makes evaluation of therapy difficult.

Repeated infections are common. In this case it was in the form of repeated attacks of bronchial asthma associated with pneumonia and bronchitis. This is probably due to impairment of the immunologic responses of the body. Strober, *et al.*⁶ found reduced serum concentrations of each class of immunoglobulin, lymphocytopenia, skin anergy, and striking failure to reject skin homografts, in their series. They concluded that these diverse immunologic disorders may be due to a primary loss of both immunoglobulin and lymphocytes into the gastrointestinal tract. Studies made by McGuigan, *et al.*⁷ suggested that the immunologic defects in patients with intestinal lymphangiectasia are correlated with excessive globulin catabolism rather than intrinsic defects in immune competence.

Other studies to demonstrate rapid fecal loss of protein using radioactive tracer substances such as radioactive I-131 labeled PVP (polyvinylpyrrolidone) radioactive Cr labeled serum albumin were not possible because these materials are no longer commercially available.

The diagnosis is made by demonstrating the hallmark lesion, i.e. the dilation of the lymph channels of the mucosa and submucosa of the small intestine, and the demonstration of increased albumin loss in the gut. Differential diagnosis would require consideration of celiac disease, nephrotic syndrome, diffuse enteritis and liver disease.

There is no satisfactory treatment. None of the patients in Waldman's series³ responded to gluten restriction, steroids, or resection of the most severely involved segments of intestine. Jeejeebhoy,⁸ on the other hand, reported a remarkable return of severely impaired albumin metabolism to normal, following a large jejunal resection.

Jeffries, *et al.*⁹ reported a satisfactory response to a low-fat diet in two patients. Dietary restriction of fat has been reported to have caused disappearance of ascites⁷ and other symptoms in a case of congenital chylous ascites.¹⁰ A good response in one patient has been reported¹¹ after long term corticosteroid therapy. In recent years, a diet in which fat has been primarily medium chain-length triglyceride (MCT) has been shown to be effective¹² in the treatment of intestinal lymphangiectasia. The physiologic basis for this response is the fact that MCT is absorbed directly into the portal circulation, thereby avoiding the abnormal lymphatics. A secondary effect of this mode of therapy is a decreased formation of lymph within the intestinal lymphatics and as a consequence, the loss of lymph through the gut or the abdominal cavity is decreased.

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Saint Elizabeth Hospital

Every doctor's help is needed in support of this simple program which can practically eliminate tuberculosis among school children.

The School Tuberculosis Surveys

Edward J. Dehné, M.D./Trenton*

Each year school children are screened to detect the precursor of tuberculosis and make it possible to stop the infection in the student as well as to search out the disease source in the family and household associates. This program has uncovered 50,000 infected school personnel in New Jersey schools in the last five years.

Preventive therapy with isoniazid for these 50,000 tuberculin reactors is the basis for this school tuberculin testing procedure. Here is the key to tuberculosis prevention and eradication in New Jersey. Heretofore, only limited use of isoniazid for the 50,000 identified school reactors has been prescribed.

The development and transmission of tuberculosis in the school environment can be prevented by identification and treatment of the infected students and tracing the source of infection in their family and household associates. Last year in Newark alone 81 new, active tuberculosis cases were disseminators of disease in homes of school children. The tuberculin skin test is used to identify infected school children, to test the family and household associates of reactors and to identify persons to be placed on isoniazid as a prophylactic drug that is effective, inexpensive, and virtually free from any side effects in the dosage used in prevention.

Positive reactors for whom isoniazid is intended are to be given chest x-rays. The family and close associates are to be tuberculin tested. All school teachers and other school employees are to be skin tested and non-reactors are to be scheduled for annual tuberculin tests. Reactors are to receive annual chest x-rays and receive prophylactic isoniazid according to the USPHS, the American Thoracic Society, and the National Tuberculosis and Respiratory Disease Association.

Goals of the tuberculin testing program are to identify and treat infected children and to find and treat the active cases among the reactors' associates who disseminated the infection.

Many of the children infected with tubercle bacilli will develop active disease within one year of infection if no isoniazid is prescribed. Isoniazid chemoprophylaxis is believed mandatory for positive reactors through school age because of the relatively high risk attending tuberculous infection in these individuals. The State provides isoniazid free to all persons for whom it is prescribed.

Successful tuberculin testing requires planning. The support of the county medical society is essential and the interest and support of the Parent-Teacher Association is fundamental to the program. The school authorities must be included in the planning. These include school boards, faculty committees, and teachers' associations. The local tuberculosis association can be of assistance in providing information and publicity.

*Dr. Dehné is State Tuberculosis Coordinator in the New Jersey Department of Health.

Multiple puncture tuberculin tests are used for school screening programs because of their simplicity. All detectable reactions to a multiple puncture test should be retested with a Mantoux test using 5TU, PPD. Estimates can be made as to how many children and adults will need tuberculin tests, x-rays, and medical services including preventive therapy. About 95 per cent of the number of children enrolled will participate as some will be absent. About one per cent of all first graders will have positive reactions. The family associates of reactors should be skin tested. The average number of associates can be roughly estimated at five per child reactor—two adults and three other children. Nearly 30 per cent of the associates will have positive tuberculin tests and will need chest x-rays. The same system applies to 5th, 9th, and 12th graders, except that the reactor rate will be higher: two per cent and five per cent. Approximately 20 per cent of the school employees will be positive reactors. These estimates

used in planning will lead to relatively little waste.

Since 1952, isoniazid has been extensively used throughout the world both for treatment as well as for preventive therapy. Extensive use by the U.S. Public Health Service, the military services, and in foreign countries has shown that *isoniazid can reduce the incidence of tuberculosis in tuberculin reactors*. Curry[†] showed 60 times higher tuberculosis disease rates among those who did not receive isoniazid in the San Francisco schools.

Isoniazid prophylaxis is the purpose of school tuberculin testing programs. The preparatory health education for students and parents should include information regarding preventive treatment with isoniazid, which acts by diminishing the bacterial population in the initial invisible lesions.

[†] Curry, M. J. *AMA Archives of Environmental Health* 32:1002 (June 1969)

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Narcotic Identification Guide

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one. Information was secured from the U. S. Bureau of Narcotics and Dangerous Drugs in Washington, D. C. It is easily mailed in an ordinary business size envelope. Cost per 1000 is 20¢ each, with the price reducing to 10¢ per item for larger quantities.

The smaller, three by five inches, is a slide chart which highlights a dozen different drugs and the physical symptoms, what to look for, and the dangers of each one. It includes a listing of symptoms common to all narcotics. Information was secured from the Office of the District Attorney in Queens, New York. Cost is \$65 per 1000 and may be as low as 2¢ per item for larger quantities. For details, write to the National Dealers Service, 33 Rockwell Place, Brooklyn, N. Y.

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Papillitis, Gallstones, And Pancreatitis*

Victor D'Ambrosio, M.D./Murray Hill

Could gall stones and recurrent pancreatitis have a common cause? This query remains unanswered. Here is a case which has some value in answering that significant question. The anatomy of the choledochal junction, although very complex, is well defined. Functionally, the most important element is the sphincter choledochus.⁷ Tonic contraction of this muscle is responsible for the filling of the gallbladder in intervals between meals. Its relaxation permits discharge of bile into the intestine. Contraction of the Ampulla of Vater may result in reflux of juices into the pancreatic and bile ducts at the point where the two structures have a common entrance into the duodenum, or into each one where the two ducts are separate.

Some patients with biliary tract disease and stones develop pancreatitis, regardless of the surgery performed on the gallbladder and common duct, unless a sphincteroplasty is also performed. Obviously stones and cholecystitis are not the cause of pancreatitis. Some patients who have pancreatitis go on to develop gallstones and cholecystitis.

Our case is one in which pancreatitis existed before any gall stones developed. Several gallbladder series taken in the past had been normal, but bouts of pancreatitis continued to recur. The pancreatitis was caused by the inflammatory process taking place at the duodenal choledochal junction, producing fibrosis of the Sphincter of Oddi. This was shown by biopsy. (See Figure I)

The arrangement of the sphincter in this pa-

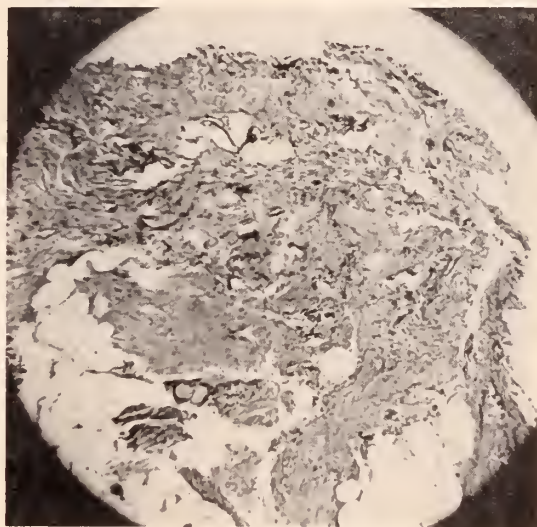


Figure I—The above microphotograph of the biopsy of the Sphincter of Oddi shows diffuse chronic inflammation and extensive fibrosis which has almost completely replaced the muscle layer.

tient was that of the common channel. The preoperative cholangiogram[†] showed a retrograde filling of the pancreatic duct without dilatation of it. (See x-rays, Figures II and III)

Following the duodenotomy, the sphincter was found to be stenosed, fibrotic, and hard to probe. Our findings are also in support of the thesis that papillitis did exist and that the cholesterol crystals scattered in the gallbladder's mucosa were not of a size capable of producing severe attacks such as the patient had been experiencing during the past ten years. Here we have the exact condition Nardi, *et al.*¹ have been talking about—pro-

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†Cholographin used in this study was furnished by E. R. Squibb & Son.



Figure II—This pre-operative cholangiogram shows a normal extrabiliary tract without stones or dilatation of the biliary ducts. Beautifully visualized is the pancreatic duct which is normal. Note the common channel arrangement. T-tube is well in place.

claiming the existence of papillitis as the cause not only of recurrent pancreatitis, but also perhaps of gallstones.

The suggestion that gallstones form in the presence of stenosis and infection seems to be borne out in cases like this. The cause for the formation of stones and of pancreatitis in such cases, I believe, must be found in the changes of the anatomy of the organ whose function has been altered. Changes in the choledochal duodenal junction are:

Fibrosis of the sphincter; stenosis of the sphincter; reflux of bile and pancreatic juices into the respective ducts; and infection and stenosis.

This theory was exposed in my previous report² on congenital anomalies of gall bladder and bile ducts.

The most significant and decisive step in the treatment of our patient with regard to surgery was yielded by the results of the evocative test. This test was an injection of 10

milligrams of morphine and one milligram of prostigmine intra-muscularly. Within 30 minutes, following this injection, the amylase climbed to 288 units and the patient experienced a full blown attack of pancreatitis. This was, to me, proof of the need to explore the sphincter and suggested sphincteroplasty as the way to a permanent cure in this patient. We did obtain a full recovery without any recurrence within the last four years.

It has been stated that the management of the patient with recurrent pancreatitis is still controversial and that it will remain so until a better understanding of the underlying causative mechanism is achieved. But this report is testimony to the fact that there are cases in which the mechanism of pancreatitis (with or without gallstones) is obvious and so is the surgical management.

There is a definite papillitis with spasm and stricture of the Sphincter of Oddi which produces this form of pancreatitis. The surgical



Figure III—The pre-operative cholangiogram shows a normally filling gallbladder with a phrygian cap and no evidence of cholelithiasis.

treatment should be a transduodenal sphincterotomy with removal of the gallbladder and with exploration of the common bile duct. The works of Dubilet and Mulholland⁴ have pointed up different versions of the same problem.

The inflammatory process reaches its maximum etiologic significance when it affects the sphincter's muscular and mucosal complex. It makes little difference whether the common bile duct and the pancreatic duct have or do not have a common channel. The end result is papillitis with obstruction.

The patient with pain in the right upper quadrant needs a broad diagnostic approach. All patients with acute cholecystitis should be considered as possible candidates of recurrent pancreatitis. To confirm the diagnosis there are pancreatic enzyme studies as well as the evocative test, which may be followed by an acute attack of pancreatitis along with an elevation of temperature and an increase in white cell count.

American physicians are primarily responsible for developing a scientific approach to the problem of the pathology of the Sphincter of Oddi as it relates to recurrent pancreatitis.

In reviewing this case in the light of present day knowledge of papillitis as a distinct entity, it was gratifying to read that in France physicians are beginning to recognize this. They report⁵ evidence to the cause and relationship of recurrent common duct stones and pancreatitis. Alexander⁶ cited a study of fourteen patients with recurrent gall stones. In his judgment precipitant factors were: inflammation of the Sphincter of Oddi in six patients; pancreatitis in three; duodenal biliary reflux in two; and unknown cause in three patients. Sphincterotomy and choledochoduodenotomy in older patients were advocated.

The inflammatory process in the Sphincter of Oddi is definitely the primary factor in recurrent calculi in the common bile duct and in pancreatitis.

This patient was admitted with vomiting and with acute severe epigastric pain radiating to back. He appeared slightly jaundiced and had mild temperature elevation. Pain and deep tenderness localized in mid-epigastrium.

Oral cholecystogram: No radio-opaque or lucent calculi within the gallbladder. Following fat stimulus there was partial evacuation of the content. There was toxic granulation in granulocytic series. Bilirubin total was 2.80—direct 0.80, indirect 2.00; thymol turbidity was 3.88 (0-40 U.), transaminase was 29.7 (8.40 U.), and alkaline phosphatase was 5.6.

Six months later, he was readmitted with severe mid-epigastric pain, cold sweat, and vomiting.

X-ray study: Chest normal, IVP reported normal, barium enema was normal.

Oral cholecystogram: The gallbladder showed adequate concentration of contrast media and no calculi. The upper gastrointestinal series revealed delayed emptying of stomach and poor visualization of duodenum, which appeared somewhat irritable. This finding would give strength to the Dubilet theory which considered biliary tract and pancreas as one-function unit.

A small bowel series was normal. However, there was evidence of a dilated loop across the epigastrium, defined as a sentinel loop in presence of acute pancreatitis. Serum bilirubin was 0.6; alkaline phosphatase was 12.8, amylase was 430 U. (60-160), calcium was 9.7, phosphorus was 2.5, and aldosterone and catecholamines were reported normal.

Treatment: He was treated with intravenous fluids, nasogastric suction, penicillin, and streptomycin. He was discharged with a diagnosis of pancreatitis, secondary to papillitis.

Three years later he was readmitted because of failure of medical regimen to control pain and vomiting. Serum amylase was now 442, BUN 20, serum bilirubin 0.2, and phosphorus 3.2. The patient became comfortable on anticholinergic drugs and diet. Serum amylase dropped to 88 units. Our diagnosis of papillitis, secondary pancreatitis, and cholecystitis was confirmed.

Surgery: At surgery a right upper paramedian incision was made and carried through all layers. Exploration of the abdomen revealed a normal-sized gallbladder, considerable scarring of the hepato-duodenal ligament, pancreas of normal size and consistency, cystic duct, and common bile duct also of normal size. Then the lesser sac was explored. A Kocher maneuver was done. The cystic artery was doubly ligated and divided. The cystic duct was freed and a temporary ligation applied. A straight catheter was then passed into the partly opened cystic duct and a cholangiogram performed. We had a beautiful visualization of the common bile duct, the intra-hepatic ducts, and the pancreatic duct with the Santorini duct.

The main pancreatic duct and its branches were not dilated. The duct of Wirsung and the common bile duct were seen to have a common channel. A duodenotomy incision was made longitudinally between the second and the third portions of the duodenum. A Bakes dilator was passed with ease into the duodenum. A sphincterotomy was performed. The incision was made deep into the sphincter. A piece of tissue was obtained from the sphincter and sent to the pathologist.

There were no stones in the Ampulla of Vater. The common bile duct was explored and flushed. No stones

were seen or found. A Penrose drain was placed in the Morrison's pouch and brought out with the T tube through a stab wound.

Conclusion

On the basis of the clinical and pathological evidence presented here there is no doubt that:

- (1) Papillitis exists as a distinct entity.
- (2) Papillitis leading to fibrosis, pancreatitis, and stenosis can be the cause of cholecystitis and cholelithiasis.
- (3) The biliary tree and the duodenum perform as a single unit physiologically, and, therefore, when the process of papillitis takes place both the biliary tract and the pancreatic duodenal system can be affected and lay the ground for pancreatitis and/or cholecystitis, and ultimately for cholelithiasis.
- (4) Pancreatitis and biliary tract disease (as a result of papillitis) must be borne in mind

and the surgeon's approach to a patient suspected of having either condition planned accordingly.

- (5) The evocative test is an important aid to the operating surgeon if a normal gallbladder is present.

The case reported here well supports the claim of papillitis as a separate entity.

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The seldom suspected relationship between the upper digestive and lower respiratory tracts is here emphasized and illustrated.

Pulmonary Complications Of Esophageal Abnormalities

Samuel Cohen, M.D. and Alfredo D. Recano, Jr., M.D.*/Jersey City

Esophageal lesions or disturbances of its function may be associated with pulmonary manifestations and disease as a result of "spill-over." Often neither the physician nor the patient appreciates that there may be an inter-relationship. In recent years, increasing attention has been placed on gastroesophageal reflux (with or without associated x-ray evidence of hiatal hernia), not only as an important factor in esophageal but also of respiratory complications. Recognition and treatment of the underlying primary condition may prevent pulmonary complications.

Embryologically, the air passages beyond the pharynx develop as outpouches of the foregut and the orifices of the two adult tracts are critically juxtaposed. Four mechanisms prevent regurgitation or aspiration of food or esophageal (and gastric) contents into the trachea. These are: (1) the larynx which "guards the door" to the air passages; (2) the cough reflex; (3) the pharyngo-esophageal sphincter at the level of the cricopharyngeus; and (4) the valve at the lower end of the esophagus.

Poor muscle tone of the sphincter (aside from mechanical obstruction at this junction) may result in overflow of swallowed material into the larynx or trachea. There may be incompetence at the cardioesophageal junction when it slides upward beyond its normal attachments below the diaphragm. It is most commonly associated with a sliding hiatal hernia but it may be present without x-ray evidence of hernia or absent with some hernias. Several mechanisms normally pre-

vent gastroesophageal reflux: (1) intrinsic sphincter mechanism in the lower esophagus; (2) the sling-like action of the hiatal musculature; (3) the possible valve-like action of the mucosal fold at the esophagogastric junction; (4) the acute angle of entry of esophagus into the stomach; and (5) the stretching and a lower than normal insertion of the phrenoesophageal ligament. Cinefluorography of the esophagus, as a supplementary technic to other diagnostic modalities, has provided objective criteria for evaluating esophageal reflux.

Achalasia is a chronic disorder of motility that leads to obstruction at the level of the esophagogastric sphincter. It is not actually a cardiospasm but rather failure of the sphincter to relax in the act of swallowing. The fundamental lesion is assumed to be degeneration of the ganglion cells of the myenteric (Auerbach's) plexus of the esophagus. It leads to stagnation of food and fluid because of obstruction, and aspiration or regurgitation, particularly in the recumbent position. This is the mechanism for "spill over" into the tracheobronchial tree.

Diverticula are classified as: (1) hypopharyngeal (Zenker's)—pulsion type; (2) midesophageal—usually at the level of bifurcation of trachea—frequently the traction type; and (3) epiphrenic—usually found in association with achalasia.

Herniation through the esophageal hiatus is the most common and most important. Such hernias are frequent particularly in overweight women. There are three types: (1)

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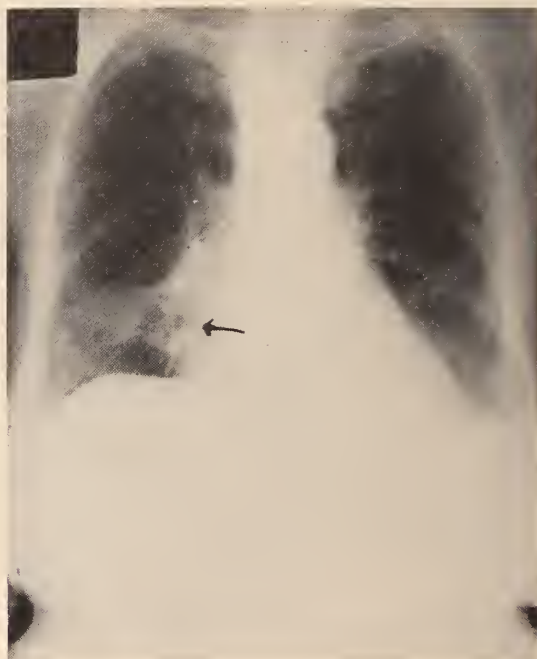
sliding—comprising about 75 per cent of cases in which the esophagogastric junction is in the thorax above the level of the diaphragm and the herniated part of the stomach is partly covered by peritoneum; (2) rolling (about 20 per cent of cases)—the esophagogastric junction is normally situated below the diaphragm. It is sometimes called paroesophageal because the hernia occurs not through the esophageal hiatus but through an opening separated from the hiatus by a small band of diaphragmatic muscle. In large hernias of this type, a portion of the colon may also be found in the sac; and (3) combined or mixed type, accounting for 5 per cent. Discovery of a hiatal hernia is not synonymous with clinical significance and it is not uncommon for such a hernia to be an incidental finding. Sometimes, large hernias may be present without any symptoms. Also, the hiatal hernia may not be the cause of the patient's symptoms; other conditions, such as peptic ulcer, gallstones, or intra-abdominal cancer, for example, may be overlooked in the presence of a hernia.

Symptoms may be due to these complications: (a) mechanical factor—the sac empties slowly after meals giving rise to pressure in the chest or retro-sternal pain (usually lower), dyspnea, palpitation. Cough and diaphragmatic irritation may cause spasms of pain or hiccough. Symptoms are frequently associated with change in posture; (b) gastroesophageal reflux—often associated with esophagitis and stricture; (c) blood loss—massive or slow oozing causing iron deficiency anemia; and (d) symptoms arising from an ulcer in the sac or peptic ulcer.

Cough and expectoration are almost universal symptoms at one time or another and may be due to a variety of causes. To place this spectrum of symptoms in its proper perspective, we have had the opportunity to observe a select group of patients in whom such symptoms were accompanied by objective radiologic findings in both the lungs and esophagogastric tract. The mechanism of aspiration accounted for the pulmonary abnormalities. Four such cases are here presented.

Case One

A female, age 75, was first seen in 1935 with a history of cough, sputum, and wheezing for about nine years. The right lung revealed dullness with rales in the lower lobe. Chest x-ray (Figure 1) showed a band of infiltration in the lower portion of the right lung. A diagnosis of probable chronic pneumonitis and asso-



Case I—Figure 1—1935



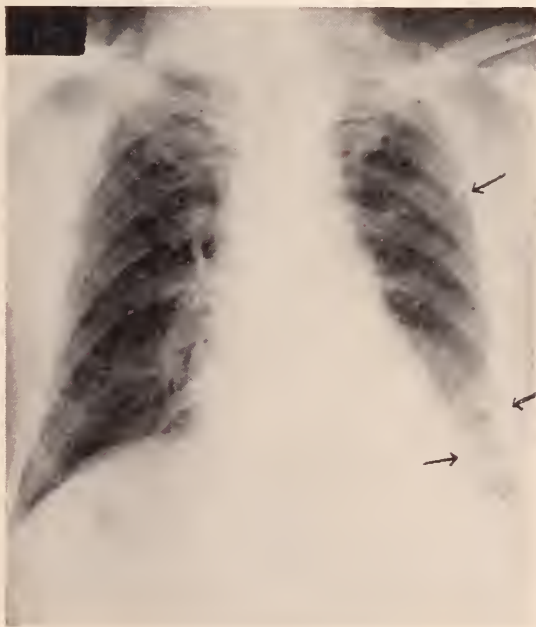
Case I—Figure 2—1966

ciated bronchiectasis was made. An antibiotic, cough expectorant, and use of steam inhalations were prescribed. The patient was next seen a year later with a recent exacerbation of symptoms. In addition, a history was now elicited of some difficulty in swallowing and frequent "choking sensation." The chest plate indicated bilateral infiltration. A gastrointestinal study (Figure 2) showed some of the opaque material in the trachea. There was no fistulous communication. The impression was that of recurrent and chronic inflammatory changes of the lungs (perhaps with bronchiectasis) as a result of a probable defective neuromuscular mechanism of the swallowing reflex. Intake of small amounts of baby food frequently was suggested—also the "sleep high" position was advocated and the resumption of antibiotics during sustained periods of increased cough and sputum.

Case Two

A male, age 69, had a history of cough and phlegm, with some shortness of breath for the past seven years. A choking sensation was often present. He noted that the food "stayed in a pocket" which he regurgitated sometimes. He coughed mostly at night. Physical examination disclosed dullness and rales in the left lower lobe. The roentgenogram (Figure 3) revealed some widening of the aorta and slight cardiomegaly, an old fibrocalcific focus below the second left anterior rib with a pleural calcific plaque along the lateral margin of the hemithorax, and definite infiltration above the left diaphragm with obliteration of the costophrenic angle.

The patient had had a barium study a year and a half before and a review of the film (Figure 4) showed a large saccular type diverticulum in the upper third of the esophagus. The pulmonary pathology at the left base was considered to be chronic pneumonitis secondary to "spill over" from the diverticulum. He called five weeks later to say he was definitely improved after utilizing essentially the same regimen as Case I.



Case II—Figure 3—1970



Case II—Figure 4—1968

Case Three

A male, age 49, reported that in the last six months, he had lost about 15 pounds. He had a cough with bloody sputum noted about two months earlier. Tuber-



Case III—Figure 5—1968

culin test was negative. Sputum was negative for acid fast bacilli but showed proteus organisms. He was placed on Ampicillin®. Further inquiry elicited that he had foul sputum for a short period and regurgitated food at times. The chest x-ray (Figure 5) showed infiltration in the right upper lobe with an area of "hi-lite." X-ray series (Figure 6) revealed marked narrowing at the cardiac end of the esophagus with dilatation above. It was felt that the patient had suppurative pneumonitis and abscess formation simulating tuberculosis on the roentgenogram and resulting from aspiration secondary to achalasia. He was esophagoscoped on two occasions and bougies were introduced. The patient's symptomatology improved and serial chest films showed a stable focal residue. An operation (Heller) was refused and he left the hospital two months later. He was readmitted six months after discharge with symptoms of shortness of breath and epigastric distress caused by greasy and spicy foods. He coughed frequently at night and had lost weight. The patient now agreed to the operation. A left thoracotomy was done with esophagogastric myotomy with an intercostal muscular pedicle. Marked dilatation of the esophagus was noted and biopsy of the muscle showed medullated nerve fibers devoid of any ganglion cells with diffuse eosinophilic infiltration of the musculature and stomach. An esophagogram (Figure 7) prior to discharge showed a decrease in the size of the esophagus with some moderate distention. Follow-up studies have indicated considerable symptomatic improvement.

Case Four

A male, age 77, was seen in another hospital with arteriosclerotic heart disease and severe rheumatoid arthritis. For about eleven years, he had frequent bouts of cough with variable amounts of sputum and shortness of breath, with occasional chest pain for six years—also frequent "heart burn" and regurgitation of liquids.

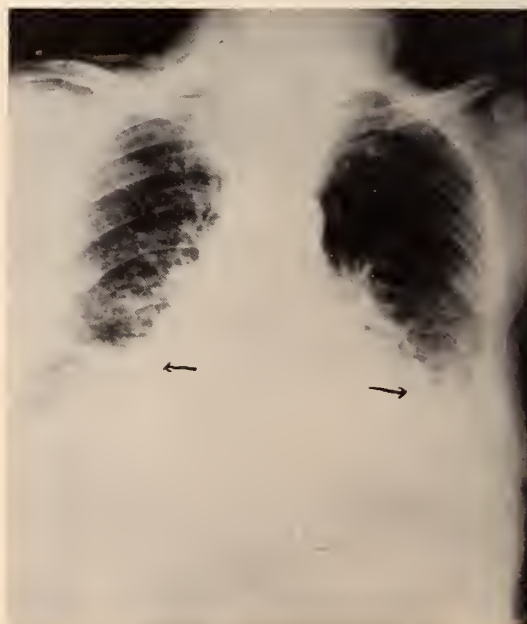


Case III—Figure 6—1968



Case III—Figure 7—1970

The patient's general condition was very poor. Lungs showed dullness and rales in both lower lobes. Sputum examinations were negative for malignant cells and tubercle bacilli. Some of the serial chest films are here presented (Figures 8 and 9) showing the recurrent bilateral lower lung field involvement. The patient received antibiotic therapy with cough expectorants.



Case IV—Figure 8—1964

X-ray series (Figure 10) revealed curling of the esophagus with a very large esophageal hiatal hernia. It appeared obvious that the patient had had repeated pulmonary inflammatory insults secondary to aspiration due to the esophageal findings.



Case IV—Figure 9—1965



Case IV—Figure 10—1965

The pulmonary complications of dysphagia *per se*, regardless of etiology, have been well described by Belcher.² Of the non-malignant esophageal lesions diverticula and achalasia have been long recognized as providing "retention traps" for aspiration of irritating contents into the broncho-pulmonary tree. Plummer and Vinson³ in 1921 first emphasized that patients with achalasia are likely to develop respiratory symptoms. Holman⁴ reported an incidence of 62 cases (7 per cent) among 934 patients with achalasia observed in the Mayo Clinic. Fifty of the 62 had aspiration pneumonitis (37 unilateral), and sometimes simulated other entities, such as tuberculosis, silicosis, or carcinoma. Fibrosis, bronchiectasis (as late sequelae), and abscess formation were also noted. Holman⁴ commented that the pulmonary complications usually manifested themselves in the advanced or decompensated stage of achalasia at which time the radiologic features are apt to be widening of the mediastinum to the right, an air-fluid interface in the esophagus (in the erect position) and absence of the gastric "air bubble." However, as in other medical conditions, the evolutionary concept should be considered and recurrent bouts of bronchitis may also be more subtle manifestations of achalasia. Others have reported instances of pneumonia due to aspirated mineral oil (floating on top of the esophageal column of fluid) and infection with saprophytic mycobacteria (not the human acid fast bacillus of tuberculosis). Once achalasia is recognized, such complications increase the urgency for aggressive therapy by means of dilatation or surgery (Heller operation).

While asthmatic wheezing and cough are commonly associated with allergy, such symptoms may occur on a non-allergic basis. Etiologic factors are varied and one such category is esophageal disorders of which gastroesophageal reflux with aspiration is probably one of the most important and least appreciated.^{1, 7, 8, 10} This reflux which can exist whether a hiatal hernia is present or not, may produce esophagogastric and respiratory symptoms with one or the other combination sometimes being more dominant. In the

former, most patients may complain of heart burn, substernal discomfort or pain, lower thoracic pain, regurgitation of esophageal or gastric contents. In the latter, symptoms of laryngitis, wheezing, bronchitis, pneumonitis may be exhibited and may, if long continued, produce fibrosis, bronchiectasis, and chronic cor pulmonale.

Hiebert and Belsey⁸ reported 71 patients with incompetency (and no associated hernia) among whom 15 (21 per cent) had aspiration pneumonitis and four had night cough relieved by surgical repair. Urschel and Paulson¹ reported an incidence of 10 per cent pulmonary complications in 512 patients with cardioesophageal incompetence. Using cinefluorography (with particular focus on a wide esophagogastric angle and the height and volume of the barium reflux) as a yardstick, the incidence increased to 61 per cent in 636 patients seen subsequent to 1961. Overholt and Ashraf⁹ cited 28 patients with hiatus hernia and long standing symptoms of cough and wheezing (six had no esophageal symptoms). After surgery, 23 had significant or complete regression of their pulmonary symptoms. Recently, Babb *et al.*¹⁰ reported two patients in whom wheezing and cough (especially nocturnal) had been chronic refractory complaints for many years (both also had esophageal symptoms of reflux). After surgical repair with elimination of the gastroesophageal reflux, their symptoms disappeared. All this should not invalidate the efficacy of medical treatment (up to a point) in the alleviation of symptoms.

The main thrust of this report is to re-

emphasize an inter-relationship between the upper digestive and lower respiratory tracts which under certain circumstances may produce symptoms in the latter region. Appropriate studies may be most revealing. The pulmonary symptomatology is precipitated by the aspiration and deposition of irritants derived from the esophagus and stomach. Patients (particularly middle age and older, overweight females, and non-smokers) with non-allergic wheezing and cough should be interrogated closely as to difficulty in swallowing, regurgitation of food or liquids, particularly at night or in the recumbent position. Once a dual involvement is strongly suspected, appropriate medical and/or surgical management can be undertaken in a more rational manner.

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Fatal Brain Swelling And Overhydration*

Sylvan E. Moolten, M.D./New Brunswick

Deaths from severe diabetic acidosis have been markedly reduced during the insulin era, particularly as our knowledge of the abnormalities of fluid and electrolyte balance has increased. But even in the hands of physicians skilled in the treatment of diabetic ketoacidosis, a significant mortality still prevails. This is often among young patients and, therefore, not attributable to underlying vascular disease or other complicating illness. The clinical picture is generally that of diabetic coma of "ordinary" type followed by unexplained deepening unconsciousness and death. In some cases one must, therefore, look for changes in the brain which defy adequate treatment of diabetic ketoacidosis with electrolytes, fluids, insulin, and glucose. Among the possibilities are cerebral edema, as in the case reported by Taubin and Matz¹ and in the two cases described by Young and Bradley.² An example of this complication is reported here.

A housewife of 23 was admitted in a coma with the following story. When she was 19 she was found to be diabetic and was placed on a controlled diet with insulin. At age 21, she was said to have had "chronic noncalculous cholecystitis and duodenitis" on the basis of a gastrointestinal x-ray study. Her prescribed diet had been 1800 calories. Dosage of insulin was raised from 35 units NPH to 40 units NPH daily but no record could be obtained of the degree of care she exercised, either in her diet or in her insulin dosage. She ignored the requirement for frequent testing of blood sugar and urine. She lost a considerable amount of weight between the time she had been last seen by her physician and the time of her admission to the hospital.

Two weeks before admission to the hospital, she developed an upper respiratory infection. During the three days before admission, her appetite was poor and she ate very little (or nothing at all) without, however, altering her dosage of insulin. In the early hours of the morning of the day preceding admission (about

2 a.m.) her husband observed that she was irrational and confused. Many hours later (9 p.m. of the same day) she was seen by a physician who suspected an insulin reaction because of absence of sugar in the urine. On his advice the patient took six glasses of sweetened fruit juice. During the subsequent hours she grew progressively more comatose. She was admitted to the hospital on the following morning in a state of deep coma. Her respirations were forceful and deep ("Kussmaul breathing"). She was restless and irrational and thrashed about in bed. She seemed markedly dehydrated. Her skin was dry and cool. The odor of acetone was noted in her breath. Her blood pressure was 125/80, her pulse was 96, temperature 100 and respirations 24. Pupils were sluggish and moderately dilated. The eyeballs were soft. Except for these findings, physical examination, including neurologic examination, was negative. The admitting diagnosis was diabetic acidotic coma, possibly complicated by brain damage resulting from previous insulin hypoglycemic reactions.

Laboratory findings on admission revealed 4 plus sugar and 4 plus acetone in the urine. The blood sugar was 476. Carbon dioxide was 9 vol. per cent; the hemoglobin 10.5 per cent; RBC 6,100,000; WBC 36,900; segmented leukocytes 66; lymphocytes 33; and one monocyte. Nonprotein nitrogen was 49 mg. per cent.

Treatment started with intravenous fluids although there were difficulties at first because of the patient's uncontrolled movements. During the evening hours, she was still in coma despite having received 1015 units of regular insulin since the time of admission. Her blood sugar was 307, acetonuria was still 4 plus, and she remained exceedingly restless, thrashing in bed. Blood pressure varied from 120/78 to 210/100. She received an additional 2000 milliliters of Ringer lactate solution with 265 units of regular insulin. Following this, her blood sugar dropped to 151 although acetonuria persisted. Attempts to overcome dehydration were continued by administering large amounts of 6-molar sodium lactate solution, Ringer-lactate solution, and normal saline intravenously to a total of 10,000 milliliters. Lumbar puncture revealed clear fluid under somewhat elevated pressure with normal cell count. During the second day in the hospital, acetonuria continued. The patient failed to come out of coma. Blood pressure had now risen to 230 systolic. On the morning of the third day her blood sugar was 306, carbon dioxide was 30 vol. per cent, and blood pressure had fallen to 80/44. Pulse rate was 54. She was cyanotic despite administration of oxygen. Pupils were contracted and fixed. The urine had now become almost completely free of acetone and was consistently

* From Middlesex General Hospital, New Brunswick, New Jersey.

negative for sugar. Shortly afterward she died quite suddenly.

Autopsy: The subject was a thin female of 23 without rigor mortis, edema, or jaundice. She was of slight build and seemed to have lost some weight recently. Postmortem lumbar puncture yielded 45 drops of clear fluid in 15 seconds. The *brain* seemed tense and somewhat swollen, weighing 1300 Grams. A slab of cerebral tissue revealed, on cut section, a conspicuous degree of swelling of the grey matter. Microscopically, pronounced "cerebral edema" was detected in the form of unusually wide perivascular spaces associated with marked compression of the small blood vessels to the point of obliteration of the lumen, apparently the result of tamponade by fluid in the perivascular space. The degree of perivascular swelling was exaggerated in many places eccentrically in the form of small cysts which bulged sharply into the neuropil, especially about venules. Varying degrees of pericellular edema were also noted, especially in the cortex. The small penetrating blood vessels of the brain were severely tamponaded by similar accumulations of fluid, distending the Virchow-Robin spaces and the overlying subpial space with corresponding obliteration of the subarachnoid space. The ganglion cells and glial cells of the brain showed no unusual features.

The pericardium and *heart* appeared normal. Both ventricles were firmly contracted in systole. The coronary arteries were delicate and smooth throughout, similarly the aorta and other great vessels. Microscopically scattered foci of interstitial inflammation were present within the myocardium, chiefly in the form of eosinophils, plasma cells and histiocytes in the perivascular areas. Many of the ventricular muscle fibers were irregularly shrunken and unevenly stained.

The *liver* was somewhat pale externally and on section. Microscopically a striking degree of hydropic swelling of the hepatic cells was present, the appearance being compatible with extreme glycogen stasis. The swollen cells had caused compression of the sinusoids to the point of almost complete obliteration.

In contrast to the bloodless appearance of the sinusoids, the portal venules were strikingly dilated within all the portal fields. Some of the arterioles were moderately hyalinized.

Grossly there were no apparent abnormalities of the *pancreas*. Microscopically, the pancreas was remarkable for the paucity of islets and for the apparent immaturity of the few islets detected; most of them consisted of ribbons of primitive islet cells with scanty cytoplasm.

Discussion

The anatomic findings were suggestive of overdose of insulin. These included the striking degree of glycogen stasis in the liver, sufficient to interfere with blood flow through the sinusoids. The islets of Langerhans were greatly reduced and primitive in appearance. Their histologic features suggested relatively little active secretion of endogenous insulin. The mild grade of subacute interstitial myocarditis was such as may be seen as part of the reaction to many types of myocardial injury and is similar to that reported in patients with severe diabetes receiving large doses of insulin. Conceivably it was either the direct result of hypoglycemia or, more likely, severe hypokalemia. Subacute interstitial myocarditis was also observed in the case reported by Taubin and Matz¹ in which sudden death occurred in a patient with diabetic ketoacidosis treated with large doses of insulin and large amounts of sodium bicarbonate.

The most impressive feature of the autopsy findings in our own case, as in the parallel instance reported by Taubin and Matz,¹ was the striking degree of cerebral edema. In retrospect this proved to be the lethal factor. The threat of brain swelling in insulin overdosage has been recognized for years.^{3,4} What is of chief importance is the necessity for early recognition of brain swelling ("cerebral edema"), whether caused by insulin or any other cause. Prompt treatment by means of dehydrating agents, hypothermia, or steroids may spell the difference between life and death and between normal life with intact neural function and useless life as a human "vegetable."

Prophylaxis of brain swelling is particularly important in hospital practice, in which the patient's need for fluids to overcome dehydration caused by vomiting or diarrhea is customarily met by generous use of parenteral solutions. This includes 5 per cent glucose in distilled water or similar electrolyte-poor solutions. The clinician's reluctance to give saline in many instances is understandable because of the key role of the sodium ion in retention of water in the blood and in inflamed body tissues. Nevertheless the lessons of many experimental and clinical studies can no longer be disputed concerning the danger of electrolyte-poor fluids as a predisposing factor to brain swelling. The neurosurgeon has mastered this lesson and uses mixtures of glucose and saline rather than glucose in distilled water in hydrating patients following brain surgery.⁵

The concept of treatment of brain swelling by osmotically active agents began in 1919 with the experimental work of Weed and McKibben.⁶ Tests were conducted with hypertonic solutions of sodium chloride, sodium sulphate, magnesium sulphate, sorbitol, sucrose, and dextrose. Generally, employment of this class of substance has gone into discard, not only because of their transient action but also because of a consistent "rebound" effect. This has been demonstrated also in the case of hypertonic urea and to some extent mannitol. Furthermore, these dehydrating agents tend to reduce blood volume and increase blood viscosity, both of which pose a threat to the patient with brain swelling in whom the small vessels of the brain are severely compromised by perivascular tamponade. Several investigators have studied the effect of macromolecular substances in the prevention and treatment of edema of the brain. Hughes *et al.*⁷ showed that the intracranial pressure of human subjects could be reduced by lyophilic serum for many hours. Such serum was used by Turner⁸ in several patients with cerebral injury, generally with success. The use of concentrated serum or plasma never gained wide acceptance, probably because of undesirable side effects, including the activity of isoagglutinins, fibrin

masses, and the ever-present hazard of serum hepatitis.

The logical substitute is normal human serum albumin. This first became available in large quantities in response to the urgent request from the Armed Forces for a safe blood substitute to be used in traumatic shock. Dextran, levan, polyvinyl pyrrolidine, and gelatin have also been tried in the emergency treatment of shock and have been considered for treatment of brain swelling. Their tendency to increase blood viscosity, particularly by causing sludging of blood cells, and certain other undesirable effects, has militated against their general use in brain swelling.

Concentrated human serum albumin, unlike concentrated plasma or gelatin, is only as viscous as whole blood with a hematocrit of 50 per cent. When injected, it lowers blood viscosity owing to hemodilution. For this reason it is more readily tolerated by patients with mild congestive failure than whole blood or other more viscous colloidal solutions. The same feature recommends its use in preference to urea or other dehydrating agents in the treatment of patients with abnormally high blood viscosity.

For these and many other reasons concentrated serum albumin should prove *a priori* an effective agent in reducing brain swelling. By increasing the osmotic pressure of blood it should theoretically balance the increased uptake of water from the blood by the neuroglial elements of the brain in the reaction to cerebral injury or lowered blood osmolality. The lowered viscosity of blood and reduced tendency to sludging of blood cells would improve the perfusion of the collapsed vessels of the brain and in so doing help to overcome reversible damage to the neurones which might otherwise lead to the patient's death.

Evidence for the effectiveness of serum albumin in reducing brain swelling was reported in 1944 by Sheldon *et al.*⁹ This was in connection with cases of head injury and later (1948) by Gates and Craig¹⁰ at the Mayo

Clinic in the postoperative treatment of brain tumor. A number of other reports¹¹ indicate the validity of this premise including the treatment of otherwise irreversible insulin coma in psychiatric patients treated with insulin.¹²

My own experience with serum albumin is limited to a few cases of post-traumatic encephalopathy with coma, an instance of anoxic injury of the brain caused by strangulation, and a case of brain swelling complicating chronic bronchitis with hypoxic encephalopathy. Results in all of these cases were prompt and gratifying. At present, the chief obstacles to the use of serum albumin appear to be either the expense of the agent or the unwillingness of clinicians to depart from traditional practices. Hopefully both obstacles will be overcome with greater experience.

Summary

Overdose of insulin plus overhydration resulted in fatal coma in a diabetic patient. The explanation of coma in this patient, as revealed by autopsy, was brain swelling. Interstitial myocarditis was also present, possibly attributable to hypokalemia. The hazard of brain swelling as a complication of overzealous use of insulin and fluid and possible

methods of prevention and treatment are emphasized.

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180 Somerset Street

Your Number Under Controlled Substances Act

The Bureau of Narcotics and Dangerous Drugs announces that the deadline for use of physician registration numbers under the Controlled Substances Act has been extended to July 29, 1971. The law went into effect May 1 this year. The Bureau advises that physicians who have applied for registration, but who have not received their BNDD number, may continue to practice without interruption by indicating "Federal registration applied for on (date)." After July 29, however, no

activity with controlled substances will be permitted without use of a valid BNDD registration number.

For those of you who have forms and who have some doubt about filling them out, we have been advised by the State Department of Health that the chief area of concern is Section 11. Since all New Jersey doctors are fully licensed to dispense any and all medications and drugs, they should check all of the boxes in Section 11.



Time-savers for you.

They're the three new simplified claim forms now in use for several specified obstetrical, gynecological and general surgical procedures. And we're planning to expand this streamlining into other fields of practice. These new, short forms are slightly larger than IBM card size and may be used for the specified services in place of the more detailed 8½" x 11" standard Service Reports. A Physician can now simply check off the service rendered, fill in the date and his fee, and mail it to us. Using the new short forms cuts down on your valuable time, and will help us make prompter payments.

BLUE SHIELD 
Medical-Surgical Plan of New Jersey



decision:

Loridine[®] I.M. Cephaloridine

1.5 to 3 Gm. daily
successfully treats many
moderately severe
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indicated for use against
susceptible organisms causing:
pneumonias following surgery
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relatively painless I.M. injection
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cephalosporin therapy

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status — urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children — not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



Loridine[®]
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatism; fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic test for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

Loridine®

CEPHALORIDINE



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

[082169]

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NEW JERSEY DOCTORS' NOTEBOOK

Address Of Retiring President*

Emanuel M. Satulsky, M.D.

To The Medical Society of New Jersey in general, and to the Union County Medical Society in particular, I shall always be grateful, for having given me the opportunity to serve our profession as the 178th President of The Medical Society of New Jersey. This past year has flown more rapidly than any other I have known because of the responsibilities, the multitudinous duties, and varied activities involved. An examination of my annual report and those of the various Councils and Committees will reveal more comprehensively these important activities, the aims and purposes of The Medical Society of New Jersey, its accomplishments, and the frustrations of this period.

The air is full of demands that the practice of medicine be wholly reorganized, and health care is emerging as a major and volatile issue in the election battle for 1972. The tempo intensified when Congress began its executive sessions on HR-1. We are being compressed into a mold. Debate has shifted from whether to adopt National Health Insurance to what kind of program we need and how big. The ticking noise you hear is a prelude to the explosion that will emanate from Washington, D.C. as the political campaigns move into high gear. A prominent proponent of the group pushing a program of universal health care, or "health security," as they style it, recently stated, "One immediate effect of our effort has been to encourage others to propose their own alternatives. Long ago, I learned that when alternatives begin to surface, you know your own efforts are paying off." Thus it is that the AMA is sponsoring its Medigap Bill with its complicated standards of income levels, tax credits, and corridors for payments. The American Hospital Association has proposed

"Ameriplan" which, if enacted, would enable your hospitals to engage in the corporate practice of medicine, and it would appear that the corporations created would exercise almost unlimited power over physicians and other health personnel and increase friction between hospital administrators and medical staffs. The American Nursing Home Association is sponsoring its own national health plan, to be called "Chronicare," that will place emphasis on catastrophic coverage and financing of expenses for long-term patients; and the health insurers have introduced their National Health Care Act "to make comprehensive health insurance accessible to all Americans and strengthen the organization and delivery of health services in this country."

As noted in my inaugural address one year ago, the 70s are proving to be a time of great change. With the announcement of the administration's health program for the next ten years, the battle lines have been drawn for the major domestic political issue of the next two years. But, whoever eventually is victorious, the physician is likely to be the loser. It appears to me to be evident and inevitable that ahead are greater and stringent controls on methods of practice and fees for service.

This proposal of the National Administration is for a minimum health insurance for all ages, titled "The National Health Insurance Partnership Act of 1971 (S-1623)," introduced on April 22 1971, paid for by the employer and the employee, with a more extensive government-financed insurance coverage for the medically indigent. A major provision in this program would be the expansion of the so-called Health Maintenance Organizations, and it is the avowed purpose of HEW to have 90 per cent of the popula-

* Presented before the 1971 House of Delegates, MSNJ, second session, May 16, 1971, Atlantic City.

tion enrolled in HMOs by 1980. In an effort to blunt the implication that this looks like a plan to reorganize medical care into a series of Kaiser-Permanente, New York's Health Insurance Plan, or Washington's Group Health Association, Dr. Roger O. Egeberg recently stated, "We are not quite sold on the HMO as a panacea. We hope that by 1976, 35 million or 40 million people can be enrolled in HMOs, but there are a lot of other things that might develop in the next few years." Part of this proposal is to pay HMOs an annual capitation of 95 per cent of the cost of Medicare in the previous year for the care of other patients in the area. Regardless of the means that Congress uses to further tax the public to support health care, these monies will filter down through regional agencies, state planners, and local institutions, and the solo practitioner would find himself at the end of a long line for payment for his services. Either way, the HMO concept seems to foretell more salaried practice instead of fee-for-service and less and less solo practice.

We must prepare ourselves for the possibility of being held to national standards beyond state licensure, for compulsory participation in continuing education, and to be judged as "primary" physicians or specialists, with individuals practicing in specialties such as pediatrics and internal medicine being called primary physicians, and the functions and scope of our practices limited and our fees determined by a health security agency.

I have appointed a Committee on Long-Range Planning and Development and have charged it to investigate all new plans and proposals, to plan the future of this Society, and properly to advise the new officers and the Board of Trustees for transmission to the House of Delegates as to our future role and actions. It will consider the value of medical society foundations as a medical care delivery system. At the recent 5th Congress on the Socio-Economics of Health Care, I heard many sincere and dedicated experts extol the virtues of the foundation concept and claim that it would bring control of costs of care and guarantee to the patient he is getting a

fair deal in receiving medical care. Others, equally sincere and dedicated, debated this concept and stated that "medical societies should be in the doctors' business and not in the insurance business." Our committee must determine whether such foundations may function as HMOs or exist in cooperation with other HMOs, assist in Professional Standard Review Organizations (PSRO) and adequately control Peer Review Organizations (PRO).

On many occasions I have been asked by members of this society whether or not changes in the procedures which our profession has used in negotiations with government and law-makers are indicated. I do not know the answer to this question except to point out that contrary to the statements of some of our critics, we ask no special favors from the public or the government. We do ask them to recognize our efforts and the multi-faceted aspects of the problems we face, and that the preservation and expansion of Health Care and Medical Care do cost a price that must be paid. I am hopeful and optimistic that the public and government will come to appreciate these facts about our profession. There are things that are wrong about our ways of practicing medicine. There is much that is wrong about our society and the way we live. But they need not be destroyed to correct their defects. I have asked the committee to study the statement of the distinguished President of The Medical Society of the State of New York, "The enforcement of our demands even though they may be just, by the threat of, or actual creation of, public peril, is contrary to every tenet of our code and tradition. Such form of group action is rapidly outgrowing its usefulness. There are no victories—only defeats."

In contradistinction to this philosophy, I heard Raymond Robillard, M.D., President of the Quebec Federation of Medical Specialists recently state, "The trend in medicine is for group practice and loss of individuality to a certain point. The only way for the medical profession to deal with government is to have a strong, union-type organization involved in

very open, clear-cut negotiations." We shall depend on our committee to make the proper study and recommendations to the officers, Board of Trustees, and the House of Delegates of this Society so that they consider and reach, if possible, some definitive conclusions as to what our future actions should properly be.

Studies and experimentation are essential for any plan thus far submitted. A study of most proposals will reveal the glaring fact that the government will tax the public, promise to deliver adequate medical care, and will demand that the medical profession subsidize the costs thereof. This is contrary to every tenet that I hold and I shall continue to oppose it in every possible way. What is necessary is a clearly thought-out and consistently implemented policy on health care—not a patchwork of new laws on top of those passed earlier by politicians seeking to ingratiate themselves with the voters. We need restructuring, not more spending without an over-all plan.

In this regard, the AMA has at long last exposed the shabbiness of the statistics' game played, for too long a time, by government-medical proponents as a means of belittling American medical care. We must continue to point out that medical care and health care are extremely expensive regardless of how they are financed or organized and their cost is of great concern to physicians. At some point in recent years almost all physicians have had to raise their fees. These increases were necessitated by the wage-price spiral and yet we continue to be harassed, criticized, and penalized by the arbitrary imposition of a ceiling on our fees and of blame on us for increasing the costs of Health Care during a period when inflation was rampant.

Health Care includes the cost of hospital care and frequently one hears the assertion that doctors alone can control the costs of this care. This is not an accurate premise. While it is admitted that 60 to 70 per cent of all hospital costs are directly due to salaries paid

hospital employees, the members of the staff have no voice or control of any kind. The members of the staff have no part in establishing the various hospital charges for rooms, drugs, laboratory procedures, specialized equipment, or other modalities. You are aware of recent modernization of hospitals with the use of cost-cutting computers and automation. All hospitals have adopted the use of "disposable" needles, syringes, towels, gowns, and drapes to cut costs of sterilization and central supply rooms. Have these saved in labor and operating costs? Have these savings been reflected in reduced charges to patients? It is proper for the medical staff to seek answers to these questions and I maintain that if members of the staff are to be held in any way responsible for rapidly escalating charges, then they should be properly represented on the governing boards of hospitals with a full vote. These members, because of their expertise in patient care and as responsible citizens of the community, should be elected by their peers and not settle for a token appointment of the president of the medical staff by the governing board. We should not be held accountable for that which we neither know about nor are in a position to influence.

I am aware of how interested you would be in a discussion of the many problems we have encountered this year in Medical Education, Health Care Manpower, Medical School Expansion, Allied Health Care Personnel, recent changes in the Medical Practice Act, Malpractice Insurance, Utilization and Peer Review mechanisms, and relations with carriers in Prepaid Insurance Programs. However, I realize the limitations on your time and will not impose further upon it. Change is all about us and swift and radical changes are freely urged upon us as citizens and members of the medical profession. However, it is the part of wisdom for us to weigh our decisions and to support those changes which are truly for the better and for the broad general good. Let us not be panicked into precipitate and irreversible changes. Let us resist proposals which would permit man-made laws to determine our ethics and professional activities.

We shall be acting as physicians are expected to act, in defense and protection of life, the health and well-being of an entire people and of a great nation. The citizens of New Jersey look to us for our best and most courageous judgment and we should live up to their expectations.

As I pass the baton to your new leadership, and wish them well, I am certain they have learned from their training and exposure to our problems that they will not be running a flat race but a steeplechase with many obstacles and hazards to be measured and assaulted. My services, my help, and my devotion are theirs to command. My sincere hope is that medicine in New Jersey will have the kind of leaders in the future who will recognize a problem before it becomes a crisis; that they will staunchly defend themselves and their profession against any unreasonable single or mass action or defamation; and that working together as peers we can eliminate the incompetent and dishonest among us and establish standards of devotion, honesty, ability, and ethics that might be emulated by others.

I salute you and thank you again for having given me this cherished opportunity to serve you as your President, and I trust that I have enhanced the honor and dignity of this honorable Society in its 205th year. I leave you with an excerpt from "Ulysses" by Alfred, Lord Tennyson to guide you in your deliberations and actions:

"... and though
We are not now that strength which in old days
Moved earth and heaven, that which we are, we are;
One equal temper of heroic hearts,
Made weak by time and fate, but strong in will
To strive, to seek, to find, and not to yield."

AMA Convention

June 20-24

Atlantic City

Trustees' Minutes

April 18, 1971

A regular meeting of the Board of Trustees was held on April 18, 1971 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

David Bacharach Allman, M.D. . . . Adopted the following memorial resolution and authorized a \$50 contribution to the Medical Student Loan Fund in memory of Dr. David B. Allman, 111th President of the American Medical Association and member and chairman of MSNJ's Board of Trustees:

DAVID BACHARACH ALLMAN, M.D.
1891-1971

Whereas, after a long life of distinguished and endearing service as a renowned surgeon and medical leader, our beloved colleague, David Bacharach Allman, M.D., has been called to his eternal reward; and

Whereas, as a dedicated and faithful member of The Medical Society of New Jersey and member and Chairman of its Board of Trustees, Doctor Allman consistently advanced the good name of Medicine and the welfare of the people of New Jersey; and

Whereas, as the 111th President of the American Medical Association, he extended the scope of his service to embrace the nation and the world, and in so doing reflected singular honor upon our Society and our State; and

Whereas, by his life we were all enriched so by his death we are all impoverished; now, therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring David Bacharach Allman, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved widow in token of heartfelt sympathy.

. . . Directed that a copy be read at the first session of the 1971 House of Delegates.

. . . Authorized the AMA Delegates to introduce a resolution to the AMA House of Delegates in memory of Dr. Allman.

Meeting on Drug Abuse and Misuse . . . Agreed to cosponsor, with the New Jersey Pharmaceutical Association, the CMDNJ at

Rutgers and at Newark, the Rutgers College of Pharmacy, and the New Jersey Public Health Association, a meeting on drug abuse and misuse, to be held at the Holiday Inn in North Brunswick on May 26, provided MSNJ be authorized to distribute the circular on the meeting to our members in Atlantic City at the time of the Annual Meeting, rather than incurring expense of mailing.

Emergency Medical Care Symposium . . . Authorized Jack R. Karel, M.D., Chairman of MSNJ's Committee on Emergency Medical Care, to attend (with expenses paid) a national symposium on Emergency Medical Care to be held May 6 and 7 in Philadelphia.

Council on Legislation . . . Approved the report of the April 15th meeting of the Council on Legislation, including the following recommended official position (as amended by the Board) of MSNJ on bills of medical import:

S-2111 —To provide that no dog brought to a pound or shelter shall be sold or otherwise made available for experimentation. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

S-2120 —To provide that the Board of Nursing shall consist of 5 members, 4 of whom shall be registered professional nurses and 1 a licensed practical nurse; to provide for a term of 5 years and to provide that appointments shall be made by the Governor from non-binding recommendations of various nurses' professional associations. *APPROVED*

S-2128 —To authorize the Commissioner of Health to contract with voluntary, non-profit hospitals for early care, treatment, rehabilitation, counseling and education of drug users and their families and to appropriate \$150,000. *APPROVED*

S-2129 —To establish in the Department of Health a Health Hazard Abatement Fund where municipalities may make application to the Commissioner for funds to defray expenses incurred in abating conditions harmful to the health and safety of occupants of buildings and structures regulated by such municipalities. *NO ACTION*

S-2131 —To include under the Flammable Fabrics Act all bedding and toys. *APPROVED*

S-2135 —To permit the Commissioner of Education to send handicapped children to private-operated non-profit day classes more than 400 miles from Trenton. *APPROVED*

S-2140 —To provide that "educational facility" under the Educational Facilities Authority Law shall include a teaching hospital. *APPROVED*

S-2181 —To declare the need for comprehensive control of child care centers and to establish a Child Care Commission. *APPROVED*

S-2184 —To authorize the establishment of county special services school districts for the education and treatment of handicapped children under rules and regulations to be prescribed by the State Board of Education. *APPROVED*

A-2073 —To require issuance of a medical license to practice medicine and surgery to persons achieving a 75% average in examinations given by the Medical Examining Board. *DISAPPROVED*, in support of the position taken by the State Board of Medical Examiners on the basis of their long experience.

A-2189 —To prohibit any person, who operates a corporation or business enterprise extending credit, lending money, or collecting debts from contacting personally or by telephone the debtor, his family, friends or place of employment for the purpose of collecting any delinquent debts owed by the debtor. *DISAPPROVED*, because the bill does not make provision to except the primary extender of credit so that he may make direct contact by telephone with the debtor.

A-2210 —To provide that no person shall purchase, obtain, or procure narcotic drugs outside a 20-mile limit of his residence except upon the written recommendation of his employer or a physician. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES*, because the means provided in this measure are extravagantly disproportionate to the very limited advantages that might possibly result.

A-2244 —To provide that it shall be a disorderly person's violation for anyone to abandon any disposable or reusable hypodermic needle or syringe without first destroying it. *DISAPPROVED*, because although the intent of the legislation is laudable, the measure imposes a disproportionate burden upon patients and physicians alike in the probably vain hope of limiting and measurably restricting the activities of illegal users of drugs.

A-2246 —To require the furnishing of drinking water and toilet facilities to seasonal farm workers while working in the fields. *APPROVED*

A-2261 —To provide that no doctor of chiropractic shall directly or indirectly publish any advertisement concerning the practice of chiropractic. *APPROVED*

A-2290 —To create a commission to study the rising cost of medical care and its effect upon medical insurance. *APPROVED*

A-2294 —To require disclosure of information relative to activities of persons who seek to influence the content, introduction, passage, or defeat of legislation. *NO ACTION*

A-2305—To prohibit podiatrists, doctors of medicine and surgery, chiropractors, and psychologists from engaging in any form of advertising, whether as individuals or through professional service corporations. *ACTION DEFERRED*, pending a conference with the sponsors of the measure in order to effect constructive amendments in the public interest.

A-2322—To provide for the licensing of maternity homes by the Department of Institutions and Agencies. *APPROVED*

A-2331—To provide that the Commissioners of Environmental Protection shall formulate and promulgate rules and regulations concerning the labeling and prohibiting, conditioning and controlling the sale of cleaning agents whose use may tend to cause adverse effects on man or the environment. *APPROVED*

A-2368—To provide for a license fee and annual registration of persons licensed to practice medicine and surgery and to increase fees for members of various professions regulated by the State Board of Medical Examiners. *APPROVED*

A-2370—To provide for a \$25 fee for a certificate of approval of health facilities and a \$75 fee for each inspection and approval of a public medical care facility. *DISAPPROVED*, because this measure would impose an added economic burden on the taxpayers for carrying out a procedure for which taxes have already been collected.

... Approved a recommendation that the federal Medigap bill (H.R.4960 and S-987) be *APPROVED*.

Council on Mental Health . . . Approved the report of the March 31st meeting of the Council on Mental Health, including the following recommendations:

1. That MSNJ strongly announce its opposition to the undirected practice of psychiatric modalities, including psychotherapy, by persons not licensed to practice medicine and surgery.

2. That MSNJ reaffirm its opposition to the unsupervised practice of psychiatric modalities, including psychotherapy, by persons not licensed to practice medicine and surgery.

3. That the Council on Mental Health request the Board of Trustees for an additional sum of \$225 to cover the funding of exhibits being presented by the Special Committee on Emotional Disorders of Childhood and Adolescence, the Special Committee on Neurological and Related Disorders, and the Council on Mental Health, at MSNJ's 1971 Annual Meeting.

4. That MSNJ reaffirm its position favoring the establishment within the State Government of a separate Department of Mental Health, with a board certified psychiatrist in charge and responsible directly to the Governor.

5. That MSNJ write to Senator Maraziti, Chairman of the Senate Committee on Institutions and Welfare, requesting additional copies of the APA Survey Report, so that it might be distributed to the Board of Trustees and the Council on Mental Health.

Council on Public Health . . . Approved the report of the April 7th meeting of the Council on Public Health, including the following recommendations:

1. That The Medical Society of New Jersey support the Workshop for Tumor Registry Secretaries and Tumor Activity Chairman, which will be cosponsored by the New Jersey Regional Medical Program, American College of Surgeons, and the American Cancer Society.

2. That MSNJ is of the opinion that the interested and well-trained physician may best be utilized as a full participating member of the basic Child Study Team to evaluate, to assist in making final decisions, and to coordinate the educational and medical program for the rehabilitation of the handicapped child. There should also be an awareness within the State Department of Education of this need for medical participation at both State and local level.

3. That the Board of Trustees officially change the position of the Society on S-636 from "approval" to "disapproval" in order to make the Society's position on fluoridation consistent throughout.

4. That MSNJ formally adopt as its official position the mandatory fluoridation of all public potable water supplies on a statewide basis under regulations to be promulgated by the proper state agency or department as the only feasible method to accomplish fluoridation of public water supplies in New Jersey. (Italics indicate amendment by the Board of Trustees.)

Finance and Budget Committee . . . Approved the report of the Committee on Finance and Budget, including recommendations to the 1971 House of Delegates. The entire report will be included in the Transactions Issues of *The Journal* (July) and is not preprinted here.

Committee on Medical Education . . . Approved the report of the Committee on Medical Education, including the request that the following recommendation, which was approved by the Board of Trustees on January 18, 1970, be distributed to hospital administrators, chiefs of staff, and directors of medical education:

That the Board of Trustees of The Medical Society of New Jersey strongly urge every member of The Medical Society of New Jersey to participate in the AMA Recognition Award Program.

Committee on Politics and Medicine . . . Approved the report and recommendations of the Special Committee on Politics and Medicine, as follows:

In contemporary America, because of the intimate participation of politics and government at all levels of health care, the physician can no longer remain aloof. The physician should, therefore, become increasingly knowledgeable in regard to the impact of political activity on health care, the practice of medicine, and the physician as an individual in society. To do anything less would be to disregard his obligation to protect the interests of the public and of the profession. Legal opinions state that:

1. The Medical Society of New Jersey is free to, and should, educate physicians in the need for a realistic view of politics and of measures affecting medical care delivery.
2. The Medical Society of New Jersey is free to, and should, take a stand on matters affecting quality and delivery of medical care and in protection of the interests of the citizens of New Jersey in this field.
3. Any financial or political support of a given candidate by The Medical Society of New Jersey is untenable under our existing charter and current IRS rulings.
4. A physician as a citizen is free to, and should, take a stand concerning candidates or issues affecting him as an individual, or the general good as he sees it.

In view of the foregoing the Committee recommended (and the Board approved):

1. That the Council on Legislation continue intensively to study and, as indicated, to revise the legislative contact system for increasing effectiveness.
2. That the aims of JEMPAC be endorsed.
3. That members of The Medical Society of New Jersey be encouraged to join JEMPAC.
4. That The Medical Society of New Jersey have no official ties with JEMPAC.
5. That JEMPAC be more responsive to the wishes of individual members in its process of selecting candidates and issues, and that it aggressively stimulate interest on the part of component societies by appearing before them or by using other means of increasing membership in and support of JEMPAC.

Louis F. Albright, M.D., Memorial Laboratory . . . Honored Dr. Louis F. Albright with a standing ovation, when it was announced

that the Fitkin Memorial Hospital has named its cardiovascular laboratory "The Louis F. Albright, M.D., Memorial Laboratory."

Committee on Traffic Safety . . . Approved a request from the Chairman of MSNJ's Special Committee on Traffic Safety that the Committee be discontinued.

The Roving Symposium

One of the educational programs of the current academic year being supported by the Academy of Medicine of New Jersey (in conjunction with The Medical Society of New Jersey) has been a series of roving symposia. Thirty such meetings in hospitals throughout the state have been, or will be held. Purpose of these seminars is to provide speakers of outstanding reputation to discuss subjects of interest to practicing physicians. Assignment of topics has been made by a combined decision of the host hospital and the program chairman.

The format of each program, as a rule, has consisted of a formal presentation of some 20 minutes by each of two speakers, followed by an open discussion encouraging the audience to participate. Each session should be completed in approximately one hour and fifteen minutes. A moderator (designated by the host hospital) makes prearrangements with the speakers regarding the content of the formal presentation so that maximum benefit may be derived.

These seminars have been used in conjunction with staff meetings, as part of ongoing educational programs, or as individual teaching exercises. They are of sufficiently broad interest to attract physicians from many specialty areas.

Plans are now being formulated for next year's schedule. For further information, you are asked to communicate with the Program Chairman, Roving Symposia, Academy of Medicine of New Jersey, 307 Belleville Avenue, Bloomfield 07003.

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Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during April 1971:

	1971 April	1970 April
Aseptic meningitis	11	11
Primary encephalitis	2	7
Post-infectious encephalitis	0	0
Hepatitis: Total	432	324
Infectious	334	259
Serum	98	65
Malaria: Total	13	6
Military	11	5
Civilian	2	1
Meningococcal meningitis	8	16
Mumps	317	480
German measles	191	136
Measles	262	306
Salmonella	77	51
Shigella	17	14

Viral Central Nervous System Disease

Three hundred forty-three cases of acute central nervous system disease of presumed viral etiology were reported to the New Jersey State Department of Health during 1970. Included in this category are aseptic meningitis and encephalitis. The over-all figure represents an increase of 22 per cent compared to 1969.

Aseptic meningitis accounted for 316 cases (92 per cent) of viral central nervous system disease reported, an increase of 31 per cent over the 241 cases for 1969. The seasonal incidence followed the consistent summer-early autumn pattern of previous years, with onsets in 71 per cent of patients occurring during the four month period July through October. Infants and children under age 15 accounted for 65 per cent of the aseptic meningitis cases, with the 5 to 9 year age group accounting for 25 per cent of all cases. Males were more frequently affected, comprising 64.6 per cent of the year's total. All counties reported cases of aseptic meningitis, and the over-all attack rate for the state was 4.4 per 100,000 people. Specific viral agents were identified by viral isolation or serologic studies in 15 cases (4.7 per cent of the total). The most frequently implicated agent was mumps, which ac-

counted for 6 cases. The others included coxsackie, echo, and reoviruses.

Morbidity from *encephalitis* declined from 41 cases in 1969 to 27 cases in 1970. No cases of mosquito-borne, arboviral encephalitis in humans were documented in New Jersey during 1970. A diagnosis of eastern encephalitis was established in fifteen horses, ten of which died. Specific viral agents were identified in four of 27 cases of encephalitis. These included one case of measles and three cases of herpes simplex encephalitis. A specific etiology was not established in the remaining 23 cases which are grouped in the generic category of "primary encephalitis," although two of these were attributable to measles on clinical grounds.

Immunizable Diseases—A Resurgence?

The following excerpt is taken from a paper delivered at the Eighth Annual Immunization Conference, sponsored by the Center for Disease Control, U.S. Public Health Service:

"Measles is out of control, diphtheria is at its highest incidence in eight years, and poverty areas of some of our major cities as well as certain rural areas are ripe for a polio epidemic. Over-all, the picture of immunization practice in the United States in 1971 is far from bright. The time for us to be complacent about these diseases has run out." (John J. Witte, M.D., Chief of the Immunization Branch, State and Community Services Division, Center for Disease Control).

Let us not forget the suburbs as well. Recently, outbreaks of measles have occurred in at least four suburban areas. An unusual epidemiologic feature of these has been the occurrence of large numbers of cases among junior high and high school students, with relatively few cases among elementary age and preschool children.

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PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Mario I. Veluz, M.D., 128 Beatty Circle, P.O. Box 144, Westville, Indiana 46391. Manila Central University 1949. Board eligible. Group, partnership, solo. Available.

Pankaj V. Master, M.D., 88 Fallbrook Bay, Niakwa Place, Winnipeg 6, Manitoba, Canada. B. J. Medical College (India) 1960. Board certified. Partnership, solo, or will organize department. Available May 1971.

A. Bhattacharyya, M.D., 15 West Erie Street, Albany, New York 12208. University of Calcutta (India) 1954. Board eligible. Group, partnership, salaried in hospital. Available January 1972.

DERMATOLOGY—Charles Wasilewski, M.D., 844 South Lincoln Avenue, Springfield, Illinois 62704. Jefferson 1963. Board certified. Group. Available July 1971.

FAMILY PRACTICE—Nabil El-Deiry, M.D., 155 East Godfrey Ave., #0103, Philadelphia, Pennsylvania 19120. Ein Shams University (Cairo) 1959. Group, partnership, or solo. Available July 1971.

GENERAL PRACTICE—Suman K. Dass, M.D., 16-15 SW Roxbury Street, Seattle, Washington 98016. Calcutta Medical College (India) 1956. Also emergency room. Available (temporary in northern New Jersey)

INTERNAL MEDICINE—Eugene M. Kern, M.D., Box "O," Gorgas Hospital, Balboa Heights, Canal Zone. University of Pennsylvania 1965. Subspecialty, gastroenterology. Board eligible. Group. Available August 1971.

Julius M. Jaffe, M.D., 964 Del Ganado, San Rafael, California 94903. Leiden University 1963. Subspecialties, hematology and oncology. Board eligible. Association, hospital staff, or group (southern New Jersey). Available July 1971.

Barry A. Portnoy, M.D., 8008 Seawall Blvd., Galveston, Texas 77550. Emory 1966. Board eligible. Group. Available July 1972.

M. M. Rahman, M.D., 275 Bay 37 Street, Brooklyn, New York 11214. Dacca Medical (Pakistan) 1958. Board eligible. Group, partnership, or institution. Available July 1971.

Eugene F. Cheslock, M.D., 107 Beverwyck Drive, Guilderland, New York 12084. CMDNJ 1965. Subspecialty, hematology. Board eligible. Group. Available July 1972.

NEUROLOGY—Michael Weintraub, M.D., 31 Risley Road, Chestnut Hill, Massachusetts 02167. SUNY (Buffalo) 1966. Board eligible. Solo, partnership, or group. Available May 1971.

OBSTETRICS AND GYNECOLOGY—M. H. Rezaee, M.D., 2532 Queenston Road, Cleveland Heights, Ohio 44118. Pahlavi (Iran) 1959. Board eligible. Solo, partnership, or group. Available.

Myung H. Han, 1130 Stadium Avenue, Bronx, New York 10465. Woo-Suk University (Korea) 1962. Subspecialty, gynecologic endocrinology. Board eligible. Full time in a hospital, group, or partnership. Available July 1971.

Gunavantrai Shah, M.D., 1579 Rhinelander Avenue, Apt. 5Q, Bronx, New York 10461. Mysore (India) 1961. Board eligible. Group, partnership, or institution. Available October 1971.

OPHTHALMOLOGY—Herman C. Jordan, M.D., 2 George Road, Winchester, Massachusetts 01890. Howard University 1964. Board eligible. Solo, associate, or group. Available July 1971.

Robert A. D'Iorio, M.D., 8 Whittier Pl., Apt. 22F, Boston 02114. Georgetown 1965. Board eligible. Partnership or group or solo. Available March 1972.

OTOLARYNGOLOGY—Melvin J. Gunsberg, M.D., Box 3, DeWitt Army Hospital, Fort Belvoir, Virginia 22060. NYU 1963. Board certified. Group, partnership, or solo. Available August 1971.

John B. Sekel, M.D., 4823 Flanders Avenue, Kensington, Maryland 20795. Georgetown 1966. Board eligible. Group, partnership, or solo. Available July 1971.

Alvin D. Oscar, 3319 Royal Oak Court, Columbus, Georgia 31907. Jefferson 1964. Board eligible. Partnership or associate. Available October 1971.

PATHOLOGY—A. Ronquillo, M.D., 310 Washington Street, Newark, New York 14513. University of Santo Tomas 1961. Board eligible. Partnership or hospital. Available.

William D. Kelly, M.D., 801 Larchmont Road, Elmira, New York 14905. Georgetown 1947. Board certified. Available May-July 1971.

PEDIATRICS—Leon F. Kukla, M.D., 4730 North Post Road, Indianapolis, Indiana 46226. New Jersey College of Medicine 1966. Board eligible. Group, partnership, or institution. Available August 1971.

Richard G. Judelsohn, M.D., 2026A Tycoon Road, Atlanta, Georgia 30341. SUNY 1967. Board eligible. Associate or group. Available July 1972. (Buffalo)

Abdolrasool Ebrahimi, M.D., 81-11 45th Avenue, Apt. 3E, Elmhurst, New York 11373. Teheran (Iran) 1959. Board certified. Solo, group, or partnership. Available July 1971.

PHYSICAL MEDICINE AND REHABILITATION—Pravin Panchal, M.D., 2441 Webb Avenue, Apt. 5A, Bronx, New York 10468. Gujarat University (India) 1965. Board eligible. Hospital. Available July 1971.

RADIOLOGY—Gamal-Eddin H. Hussein, M.D., 2411 Fifth Street, Fort Lee, New Jersey 07024. Ain-Shams University of Medicine 1957. Board eligible. Any position. Available.

SURGERY—Gan L. Maddinar, M.D., 41-30 43rd Street, Sunnyside, New York 11104. Nagpur College (India) 1962. Board certified. Group, partnership, or academic. Available February 1971.

Candido Deborja, M.D., 280 River Road, Apt. 4-B, Piscataway, New Jersey 08854. University of Santo Tomas 1961. Board certified. Group or partnership. Available.

Choon Myong Park, 8700 Pennsburg Place, #4, Richmond, Virginia 23229. Seoul National University 1960. Board eligible. Group or partnership. Available July 1971.

Nemesio M. Elefante, M.D., 18724 Walkers Choice Road, Apt. 2, Gaithersburg, Maryland 20760. Santo Tomas (Philippines) 1959. Board eligible. Solo, group, or partnership. Available July 1971.

Abolfath B. Ardalan, M.D., 12300 McCracken Road, Cleveland, Ohio 44125. Tehran (Iran) 1962. Subspecialty, thoracic and vascular surgery. Board eligible. Group or partnership. Available July 1971.

UROLOGY—T. Jagannathan, M.D., 1 Liberty Street Apt. 6, Little Ferry, New Jersey 07643. University of Madras (India) 1961. Board certified. Group or partnership. Available.

Richard W. Keesal, M.D., 4905 East Harry Street, Apt. 115, Wichita, Kansas 67218. Jefferson 1964. Board eligible. Group, solo, associate, partnership, or government. Available August 1971.

M. A. Fermaglich, M.D., Munson Army Hospital, Fort Leavenworth, Kansas 66027. Brussels 1964. Solo, partnership, or group. Available October 1971.

Moustafa S. Naguib, M.D., 1325 South Grand Avenue, St. Louis, Missouri 63104. Ein Shams University (Cairo) 1961. Board eligible. Solo, Associate, or group. Available July 1971.

Shah M. Chaudhry, M.D., 102 North Main Street, Cape May Court House, New Jersey 08210. Punjab University (Pakistan) 1956. Board eligible. Group or partnership. Available July 1971.

Neonatal Convulsions

"Managing the Neonatal Convulsion" is the topic for the June 23 meeting at the Pascack Valley Hospital, Old Hook Road, Westwood. The speaker, William C. Ellis, M.D., is the coordinator of pediatric education at Monmouth Memorial Medical Center. This seminar will open promptly at 11:30 a.m. in the conference room of the hospital. The New Jersey Chapter of the National Academy of Pediatrics is sponsoring the program, and it is supported in part by grants from Mead-Johnson, Schering, Ciba, and Bristol Laboratories. For details, write to Harold Lakin, M.D., Old Tappan Road, Old Tappan, N. J.

Council and Committee Chairmen 1971-1972

Aleoholism

George Rogers, M.D., Camden

Annual Meeting

James A. Rogers, M.D., Paterson

Cancer Control

To be appointed

Child Health

William J. Farley, M.D., Nutley

Conservation of Vision, Hearing, and Speech

Frank B. Vanderbeek, M.D., Paterson

Constitution and Bylaws

To be appointed

Credentials

Louis F. Albright, M.D., Spring Lake

Drug Abuse

Henry A. Davidson, M.D., East Orange

Emergency Medical Care

Jack R. Karel, M.D., Hillside

Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., Paramus

Environmental Health

Roslyn Barbash, M.D., Teaneck

Finance and Budget

Thomas C. DeCecio, M.D., Cliffside Park

Honorary Membership

Ralph M. L. Buchanan, M.D., Phillipsburg

Judicial

John S. Madara, M.D., Salem

Legislation

Jesse McCall, M.D., Newton

Maternal and Infant Welfare

John D. Preece, M.D., Trenton

Medical Defense and Insurance

William J. D'Elia, M.D., Neptune City

Medical Education

James A. Rogers, M.D., East Orange

Medical Services

Louis K. Collins, M.D., Glassboro

Medical Student Loan Fund

William Greifinger, M.D., Belleville

Medicine and Religion

Luke A. Mulligan, M.D., Leonia

Mental Health

Robert S. Garber, M.D., Belle Mead

Mental Retardation

Miles E. Drake, M.D., Vineland

Neurological and Related Disorders

J. Lloyd Morrow, M.D., Passaic

Occupational Health, Workmen's Comp. & Rehab.

To be appointed

Project Hope/Vietnam

Thomas C. DeCecio, M.D., Cliffside Park

Publication

George B. Sharbaugh, M.D., Trenton

Public Health

Robert G. Salasin, M.D., North Wildwood

Public Relations

John J. Crosby, Jr., M.D., Jersey City

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Vineland

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Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccination, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance

doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9- α -fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance, electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

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LETTERS TO THE JOURNAL

The Case For The Compensation Doctor

March 31, 1971

Dear Sir:

As an internist who has devoted many years to the field of Workmen's Compensation, I object to the views expressed in Dr. Robert A. Goldstone's letter in the March, 1971 *Journal*. He has done a great disservice to the many fine physicians, lawyers, and judges engaged in this area.

Under the present system an injured workman employs the services of a lawyer to represent him in his claim. He will be wise to hire one who specializes in the field, because it does require a great deal of special knowledge. The lawyer refers his client to a physician who is an expert in evaluating causal relationship and disability. This requires not only specialist training in the particular field, but years of training in evaluating disability. Most of the physicians are board certified, or, at least eligible. It is nonsense to say that the lawyer sends his case to "a doctor who will run up a big bill" or "give a high estimate." Such tactics give rise to distrust on the part of the judge and insurance company, and are self-defeating. Later the insurance company sends the client to their own expert. This physician weighs the objective and clinical findings to arrive at his opinion. He finds out very quickly that unreasonably low estimates of disability make his opinions valueless with the judges. An insurance company has no use for an expert whose testimony is not believed, and has no hesitation in discarding him. And this holds for the loftiest professor from any medical school. It is anticipated that there will be a reasonable spread in evaluating disability, depending on which side the opinion is expressed. But this is not a "forced" opinion. I know of no doctor, who has done this work over many years, who expresses an opin-

ion that he does not honestly and deeply believe. But I do know of many doctors who have refused to give opinions that a lawyer pressed them to express. In my own experience, I have had many a lawyer express his dissatisfaction with my estimate of disability as being too low, but rarely a request to change it.

Probably the greatest influence in achieving an equitable system is the Judge of Compensation. It takes time, experience, and seasoning to produce a good Judge of Compensation. But these men and women develop expertise in evaluating the merits of a case and in dispensing justice. The statement that "the Judge, in Solomon-like wisdom, will find an average" is hardly worthy of refutation. The judges work hard and long to settle cases and in the great majority the cause of justice is admirably served. Since all testimony is given under oath and recorded, and cases may be reviewed by the upper courts or the Bureau, everyone involved in the system is careful as to how he expresses himself on the record.

The suggestion of Dr. Goldstone that "any doctor who gives more than sixty per cent of his testimony for either side, in a given year, should be disqualified" would sound the death knell of Workmen's Compensation. The present system survives because of the devotion of a small group of physicians who are expert in the field in evaluating disability for either petitioner or respondent, and because their opinions are valued and understood by both sides and the judges. Remove them and the present system will collapse.

This is the reason that most cases are disposed of by settlement, and never reach the trial level. As a matter of fact, when a case is tried, it is usually because of some legal or technical disagreement, and not the medical. I know of several physicians who attempted to be experts on either side, and their services were so used. Invariably the attempt was unsuccessful, and discontinued with consent of the physicians and lawyers concerned. There is no such thing as a purely "impartial" physician, any more than there are "impar-

tial" panels. But there are honest and conscientious physicians who give their opinions within the context of their own background, training, and convictions.

There may be a few bad apples in the medical and legal barrels, who do not follow the best ethical precepts in their medicolegal work, or in their private practice for that matter. But this is not to say that the entire barrel is tainted, as Dr. Goldstone would have us believe. I deplore his viewpoint.

(Signed) Saul Lieb, M.D.

Nothing But The Truth

April 2, 1971

Dear Doctor Davidson:

This is in response to a letter in the March 1971 issue, entitled, "Deplores Medical Testimony." This letter impugns the integrity of the medical and legal profession.

I wish to register my objection to the editorial policy of *The Journal*, which allows such statements to be published in the official *Journal* of The Medical Society of New Jersey.

That letter loses sight of the important fact that the legal profession functions on an adversary system and the medical profession does not. Thus, no pressure could be exerted upon a physician to cause him to join the adversary system. But, because some doctors do join the adversary system when they get into court, the confusion occurs. I grant that there is oftentimes a great disparity in what legally is decided and what should be medically decided—to the extent that I often categorize these as a legal diagnosis and a medical diagnosis. The disparity occurs because doctors (when they are asked to testify) allow various influences to weight their opinions away from the strictly medical approach.

Doctors, by becoming adversaries, have been the primary source of this situation. Some better system of settling medico-legal prob-

lems (particularly in compensation and accident cases) might be found. However, we must, for the present, live with the system as it is now conducted. In such a system, we doctors must be sure that our opinions adhere to the best concepts of the science and art of medicine. A reminder to medical men who might be called upon to testify would be helpful: that they may testify only if they are the treating physician. In this case, they need testify as to their findings, diagnosis, and treatment given by them, and avoid offering etiologic or prognostic opinions. If they qualify as an expert witness, then they will be required to give opinions covering etiology and the relationship to injury, activity, circumstance, and prognosis. In this case, the expert must adhere to medical knowledge and allow nothing to influence his opinion away from the strictly medical.

Let every medical witness remember that he takes an oath as he steps into the witness stand to, "Tell the truth, the whole truth, and nothing but the truth."

(signed) Harold K. Eynon, M.D.

Dr. Eynon deplores our publishing that letter in the March *Journal*. Imagine how much deploping there would be if we refused to publish it.—Editor

A Better Way To Dispense Justice

April 8, 1971

Dear Doctor Davidson:

Count me in among the deplorers of medical testimony (Robert A. Goldstone, M.D., March 1971). My rotating internship at Kings County Hospital included three months of emergency room and ambulance service. During this period, I admitted hundreds of head injury cases. Years later I would be summoned to court, usually to swear that the signature on the chart was mine.

I sat in courtrooms for hours, intrigued by the all too frequent diametrically opposite opinions of our most eminent neuropsychiatrists.

For the Plaintiff—"This man has permanent brain damage. He will always have headaches, irritability, etc., etc. I doubt whether he will ever work again."

For the Defendant—"There's nothing wrong with this man that a cash settlement won't cure."

There must be a better way to dispense justice.

(signed) Frank L. Rosen, M.D.

Placebo Effect

April 16, 1971

Dear Sir:

The justification of drug advertising seems to be among the favorite topics of editorials that appear in *The Journal*. In the April 1971 issue we are told: "However, no exhibitor is going to rent space unless he knows that his product is of use to the doctors. So you can be sure if it is shown that it is useful."

Such dogmatism!

I recall an exhibit at the last AMA convention I attended. The ribbon clerks were handing out "literature" and samples of a new product, a placebo in the form of a timed-release capsule.

Amused and curious, I asked one of the detailmen if he could estimate the probable cost of this incredible medical break-through to the patient. He said it would probably be between 12 and 15 cents per capsule, but that it might be more because of the well-known direct relationship between cost and placebo effect.

(signed) A. Dale Console, M.D.

The success of the timed-release placebo opens the door to the next step in new-part surgery: the transplantation of the human appendix. You never can tell what will come next.—Editor

OBITUARIES

Dr. James B. Butler

One of the leaders in medical administration in our state, James B. Butler, M.D., died on March 11, 1971 at the age of 63. His M.D. came from Hahnemann and he also acquired an M.Sc. in Public Health from Harvard. For thirty years he served the Navy in high level administrative posts, retiring in the grade of captain. From 1961 to 1971, he served our State Department of Institutions and Agencies as a consultant in medical and hospital administration.

Dr. Walter W. Cox

Long one of Montclair's leading physicians, Walter W. Cox, M.D., succumbed on April 12, 1971, at the age of 84. He was a Bellevue graduate in the class of 1914, and for many years was an attending surgeon at both Mountainside Hospital in Montclair and Alexian Brothers in Elizabeth. Dr. Cox was prominent in civic affairs and for several decades was Glen Ridge school physician. He served as President of the Montclair Board of Health during the 1930s. In 1917 and 1918, he was on active duty with the medical corps of the Army of the United States. In 1942 and 1943, Dr. Cox was President of our State's largest County Medical Society, Essex.

Dr. Milton Cutler

One of southern New Jersey's best-known internists, Milton Cutler, M.D., died suddenly on April 6, 1971. Dr. Cutler, a 1936 alumnus of St. Louis Medical School, was board certified in internal medicine. He was medical director of the Kessler Memorial Hospital, and consulting internist to the State Hospital at Ancora. He was chief of the graduate educational program at the Atlantic City Hospital, where he was also attending in medicine. Dr. Cutler was a three medal winner during his army service in World War II. He won a listing in *Who's Who in Medicine*, was a

member of the American Medical Writer's Association, and was a prolific writer on medical topics. Born in 1911, Dr. Cutler was 60 years old at the time of his death.

Dr. George I. Horhovitz

One of Mercer County's best known internists, George I. Horhovitz, M.D., died on March 17, 1971. Dr. Horhovitz was a 1935 alumnus of the Jefferson Medical College and was affiliated with the St. Francis Hospital in Trenton. He was active in the work of the Academy of Medicine of New Jersey and in the affairs of our Mercer County Medical Society. He was only 61 at the time of his death.

Dr. Joseph P. Klenk

Born in 1897, Joseph P. Klenk, M.D., died on March 30, 1971. He was a 1925 alumnus of Georgetown University's Medical School. Dr. Klenk was President of the Essex County Medical Society in 1963 and 1964. He was a well-known gynecologic surgeon, identified with St. Vincent's Hospital in Montclair, St. Mary's in Orange, and Clara Maass in Belleville.

Dr. Paul F. Liva

One of our state's senior cardiologists, Paul F. Liva, M.D. of Lyndhurst, died on April 3, 1971. He received his degree at the old Long Island College Hospital in 1923, and was an early Fellow of the American College of Physicians. Dr. Liva was on the staff of the Hackensack Hospital. He was 78 years old at the time of his death.

Dr. Lewis H. Loeser

One of New Jersey's prominent neurologists and psychiatrists, Lewis H. Loeser, M.D., died on April 8, 1971 at the age of 68. He was one of the small group who founded the New Jersey Neuropsychiatric Association. An early diplomate in both neurology and psychiatry, he was affiliated in these fields with most of the hospitals in Essex County. He was the mainspring behind the development

of the model Low Cost Psychotherapy Plan, and one of the architects of the Essex County Mental Health Association. Dr. Loeser was a pioneer in the early development of group psychotherapy. He was a 1927 graduate of the medical school at Tufts University. During World War II, Dr. Loeser was a lieutenant colonel in the medical corps and commanding officer of a large army hospital based in Britain.

Dr. James E. Phelps

Born in 1896, James E. Phelps, M.D., was graduated in 1925 from the Medical School of the University of Vermont. He served the people of Passaic County for forty years, and was an internist with special skill in cardiology. He was on the staff of St. Joseph's Hospital in Paterson. Dr. Phelps died on April 18, 1971 at the age of 75.

Dr. Paul Stuart

Born in Budapest, Paul Stuart, M.D., came to the U.S.A. at the age of 32. He had received his M.D. at Prague in 1934. Immediately after coming to our country, he volunteered for and served in the medical corps of the Army of the United States. On being demobilized he went to work for the New Jersey Office of the Veterans Administration. He became a board diplomate in psychiatry, and maintained offices for the private practice of that specialty in Perth Amboy and in Elizabeth. He was affiliated with all three hospitals in Elizabeth. Dr. Stuart was 63 years old at the time of his death on April 2, 1971.

Dr. Adrian Taterka

At the untimely age of 61, Adrian Taterka, M.D., died on March 7, 1971. He was a graduate of the medical school at Edinburgh, Scotland, and was a major in the medical corps of the Army of the United States during World War II. He was an internist, with a sub-specialty in cardiology, and was a full-time therapist and examiner for the Veterans Administration Regional Office in Newark.

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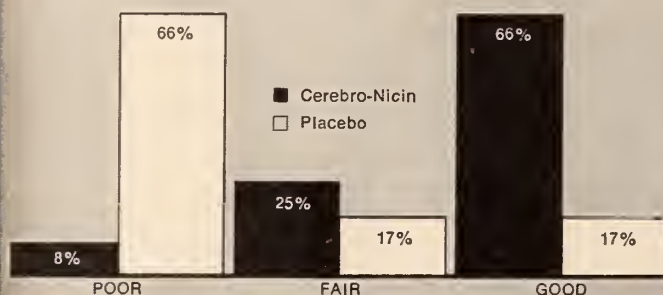
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

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Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

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Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.
References: 1. Montesano, P. and Evangelista, I. Methyltestosterone/thyroid treatment of sexual impotence. Clin Med 1:59, 1965. 2. Dulka, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:57, 1964. 3. Triloff, A. S. Methyltestosterone/thyroid in treating impotence. Gen Prac 25:6, 1967. 4. Haiman, L. Braden, M. L., Zamoff, B., Fukushima, D. K. and Gallagher, T. F. Thyroid androgen interactions and the hypohormetic effect of androstenedione. J Clin Endoc 19:936, 1959. 5. Farver, L. J. and Gaffney, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osell, A. and Farfar, G. E. United States Dispensary, ed 25. Lippincott, Philadelphia, 1955, p. 1432. 7. Wertheim, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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BOOK REVIEWS

Progesterone. (Ciba Foundation). Edited by G. E. W. Wolstenholme and Julie Knight. Baltimore, 1969. Williams and Wilkins. Pp. 193. Illustrated. (Price not stated)

This small book contains current experimental data in one of the most intriguing fields of physiologic research: regulation of the pregnant uterus to delay labor until term and then to initiate it. This volume is a report of a meeting in 1969 of the Study Group on Progesterone. At this session, a distinguished international panel presented reports and engaged in discussions. Direct, interdependent effects on myometrial function of uterine volume, oxytocin, estrogen, and progesterone, as well as indirect effects of maternal and fetal endocrine systems, are considered in general, and then differentially in early, mid, and late pregnancy. Related findings in the guinea pig and rat uteri are described.

The reports are replete with laboratory and clinical data on normal and abnormal pregnancies, influenced and uninfluenced by experimental procedures. The entire subject of pregnancy is considered, not merely the direct and indirect effects of progesterone (which are substantial) as the title might suggest, and one is impressed with the advances in the field over the past decade, as well as with the number of questions still unanswered.

HYMAN W. FISHER, M.D.

Healers in Uniform. Edward Edelson. New York, 1971. Doubleday. Pp. 184 (\$3.95)

Any reader of this enjoyable book will be surprised that there were Army doctors who (in spite of their daily routine work) found the time to establish monumental institutions and historic medical discoveries. It could only be done by men of vision, dedication, and determination.

Mr. Edelson has picked twelve military doctors who made landmarks in medical history. They persisted often against strong opposition and they were responsible for several contributions, each of which alone would be considered a memorial. Just a few examples will have to suffice.

William Beaumont visualized the great opportunity presented by the shot-gun wound of Alexis Martin's stomach. This enabled him to conduct experiments which resulted in his book that was the basis for the science of dietetics and physiology of digestion for 130 years. John Billings, in the Civil War, was the first to place hospitals near the front lines. He installed a practical system of evacuating the wounded. He established the National Library of Medicine and cataloged all the books, pamphlets, and journals from around the world. He not only built modern army hospitals, but also the Johns Hopkins Hospital and the New York Public Library.

George Sternberg became one of the world's leading bacteriologists. His "Manual of Bacteriology" was a standard reference for many years. A great monument

to him is his establishment of the Army Medical School. Then there was Walter Reed, who contributed to the elimination of yellow fever, and Bailey Ashford, who is credited for the control of hook-worm disease. And in the present period of aeromedical advances David Grant established safe aeromedical evacuation; William Lovelace, Harry Armstrong, and John Stapp, many times at the risk of their lives, conducted experiments that brought our aviation industry and space program to its present success.

While these historic events were sketchily written, this enjoyable little book is worth possessing.

Henry A. Brodtkin, M.D.

Infection Control in the Hospital. Chicago, 1970. American Hospital Association. Pp. 154. (Price not stated)

Offered here is a revision of the first edition published in 1968. It is a handy desk reference for the hospital worker. The contents include: (1) epidemiology of infection, (2) general organization of responsibility, (3) specific responsibilities of individuals and hospital departments, (4) general methods of prevention and control of infection, and (5) special problems in the control of infection. New sections touch on gamma radiation, intensive care units, and catheterization guidelines. The index is improved and the table of contents is reorganized. There is also a revision of the section on microbial sampling and isolation procedures.

The book is concise and authoritative with excellent charts, sample forms, and diagrams. Of special value is the chapter dealing with the "infection control committee," its functions, its composition, the importance of the hospital epidemiologist and infectious control nurse, and the various methods of monitoring infections and infective situations.

As with the first one, this edition is highly recommended to hospital personnel at all professional levels.

Dominic A. Mauriello, M.D.

Modern Treatment. (Vol. 7, No. 3): **Systemic Mycoses**, John P. Utz, M.D., Editor; **Calcium Disorders**, Gilbert S. Gordan, M.D., Editor. New York, 1970, Harper and Row. Pp. 212. (\$20 per year, by subscription)

This issue concerns two separate topics, fungal diseases and calcium metabolism. The first part is an excellent presentation of a topic, the importance of which, becomes greater each day. These fungal infections occur not only from the outside, but also (in these days of steroids, antibiotics, and immunosuppressors) fungi and yeast which occur normally in the body, often become invasive. This text attempts to clarify many of the problems of these diseases and prevent the all-too-prevalent errors in establishing a diagnosis. Included is an excellent article by Lounia and Armstrong describing the logical sequence of making such a diagnosis. The other articles are replete, if not redundant, with discussions of treatment with various drugs, mainly Amphotericin B.

The second topic is an interesting review of calcium metabolism, with explicit discussions of the diagnosis of the hypercalcemias, hyperparathyroidism, and hypoparathyroidism.

This issue is an excellent addition to any physician's library.

SAMUEL E. EINHORN, M.D.

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OF THE MEDICAL SOCIETY OF NEW JERSEY

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JULY 1971
VOL. 68, NO. 7

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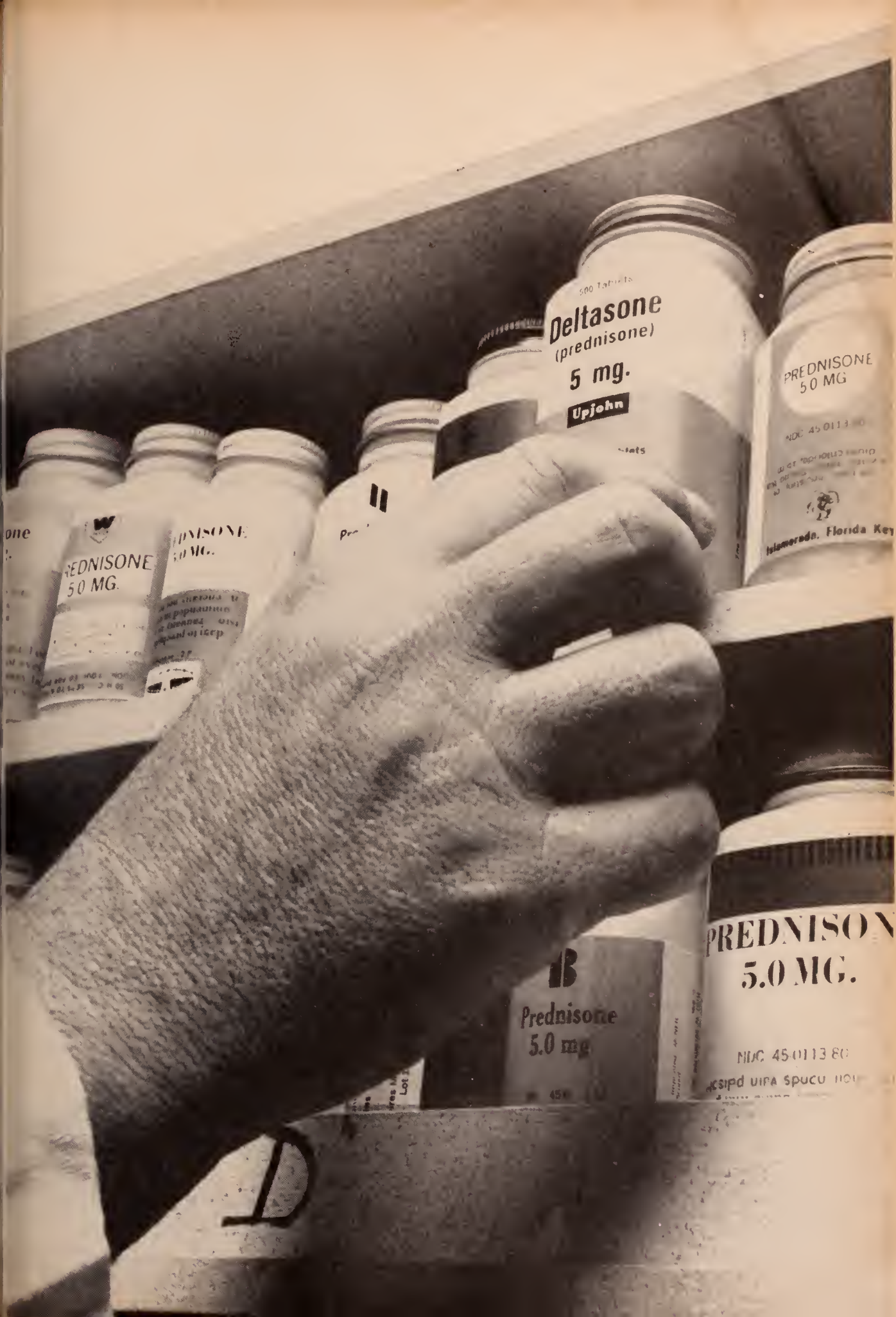
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If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective main-

tenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoid during pregnancy, since spontaneous remission of some disease such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis an ulcer regimen and antacid are highly recommended. Take X-ray in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria osteoporosis reversible only with difficulty; spontaneous fractures aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia psychic disturbances especially abnormal euphoria; nervousness posterior subcapsular cataracts occasionally requiring extraction increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

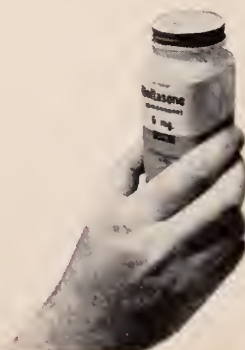
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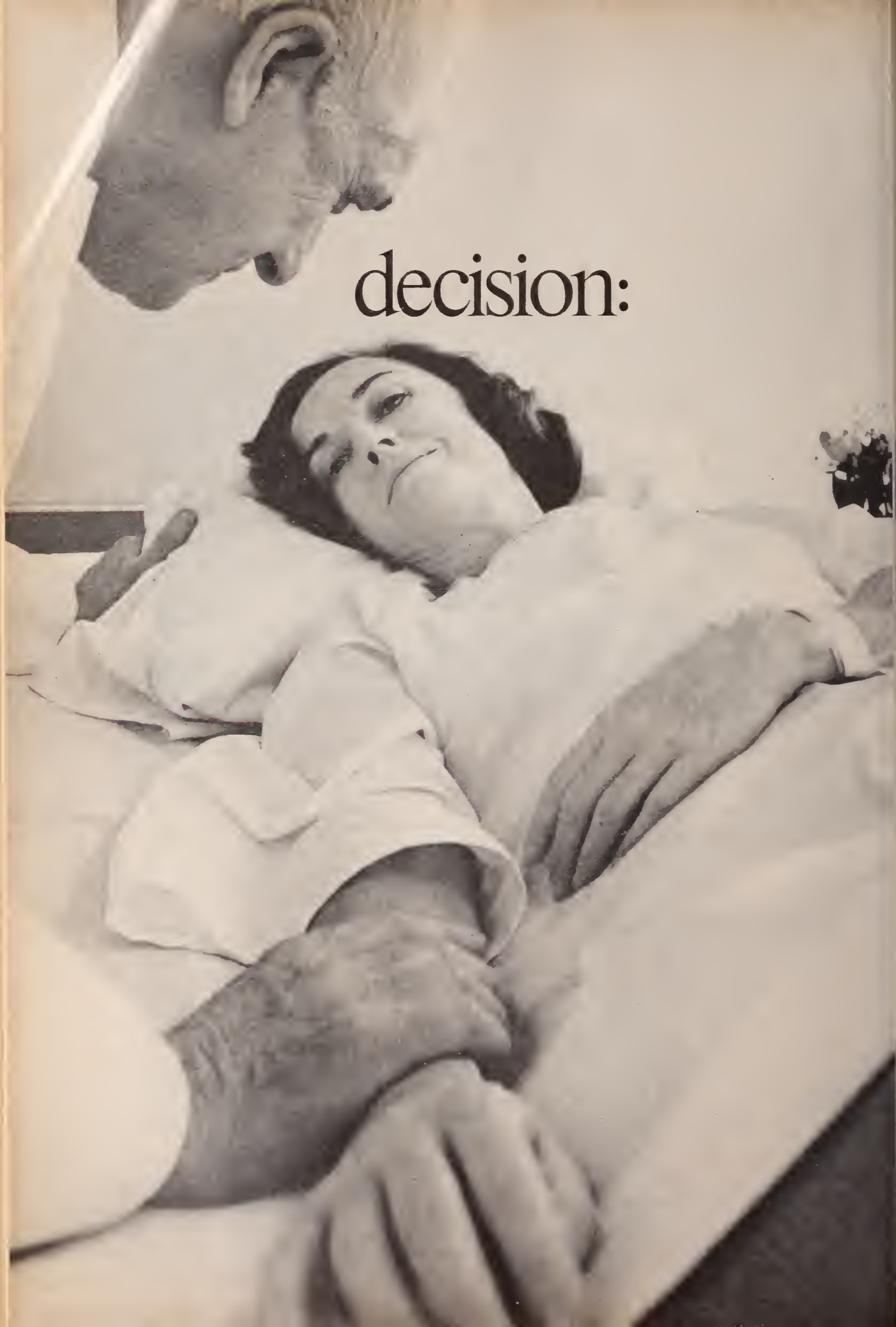
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 - abscesses
- relatively painless I.M. injection

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status — urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children — not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



100913



Loridine[®]
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extraneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

Loridine® CEPHALORIDINE



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly); 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

[082169]

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- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.
- complications in the treatment of coronary insufficiency, hypertension, diabetes, peptic ulcer or liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators¹⁻⁴ have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement^{2,4} and observation of clinical improvement.^{1,3}

Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebotic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODILAN tablets, isoxsuprine HCl 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories. **References:** 1. Clarkson, I. S., and LePere, D. M.: *Angiology* 11:190-192 (June) 1960. 2. Horton, G. E., and Johnson, P. C., Jr.: *Angiology* 15:70-74 (Feb.) 1964. 3. Dhrymotis, A. D., and Whittier, J. R.: *Curr. Ther. Res.* 4:124-128 (April) 1962. 4. Whittier, J. R.: *Angiology* 15:82-87 (Feb.) 1964.

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EDITORIALS

Declining Attendance At Medical Meetings

It seems that everybody but the members themselves have been asked to explain declining attendance at medical meetings. Our own Society's record is not too bad, but even here there was a drop. In 1968, we registered 1,112 physicians at the Annual Meeting, and at the Annual Meeting just past, the number of M.D.s registered was only 966. In June 1970, the AMA registered 8,100, whereas in 1969 the registration was over 16,000. This diminishing attendance record applies at all levels—county, state, and AMA, and in all specialties and among general practitioners.

Official explanations run the whole spectrum from rising costs (hotels, transportation, and restaurants) to "impractical" programs. Some think that the locale of the meeting makes a difference, too. Generally, resort towns (Miami, Atlantic City, and so on) outdraw big cities. In fact, doctors from some semi-rural, suburban, and other communities say that they are actually afraid to go to meetings in New York, Chicago, or San Francisco. It is sometimes suggested that with the rising tide of medical journals, and the increasing number of graduate programs, the practitioner can acquire information by reading or taking courses and doesn't have to travel very far to do either. Another thought is that with hospitals and specialty societies all demanding attendance at meetings, the county and state societies are bound to lose participants.

Most medical conventions have to depend on the rent of exhibit space to help meet the costs of the big meetings. But some of the exhibitors are becoming critical of the poor attendance and some are simply withdrawing exhibits, so the process is a circular one. Another criticism is the scheduling of so many simultaneous sessions that the program looks

like an eight-ring circus. If, for example, five scientific sessions are held on the same afternoon, a respectable attendance of 60 doctors is cut to a pathetic 12 per session—often in a hall made to accommodate 100.

All kinds of suggestions have been advanced by organizational leaders and public relations experts. One obvious suggestion is to reduce the number of simultaneous sessions. Another is to hold fewer lectures but more panel discussions with emphasis on face to face talks between knowledgeable specialists and interested practitioners. In some places breakfast discussions have been remarkably successful, partly because most of us are at maximum alertness after breakfast, and also because of their informality and the fact that there is a built-in terminal point to a breakfast meeting. Some organizations have developed a "Quiz the Experts" program, inviting tough questions from the floor.

It is truism that the members should have what they really want in a session. But how do you organizational leaders know what you want? Tell them. A letter directed to your Society's officers, or one sent in for publication in this *Journal* are two ways of writing your prescription for better medical meetings.

The Mythical Athletic Heart*

William James was once described by one of his students as an "irresistible gust of life." For James, who was a constant seeker after man's potential, the coexistence of bodily and spiritual perfection was not a coincidence. This theme, that saints are athletic and that athletes are, in some measure, saintly, and the common man can aspire to be both, never received the attention it deserved. Physicians, preoccupied with disease, consider the athlete a physiological freak.

*Abstracted from the March 24, 1971 issue of the *Red Bank Register*.

MacMillan has just published the *Encyclopedia of Sports Medicine*. It runs to 1,707 pages and embraces just about as many manuscripts filled with fact and, unfortunately, a great deal of speculation. "Probably 50 per cent of the topics," says editor Albert Hyman, "lack solid research data." Such refreshing honesty doesn't obscure the fact that what is contained will shake many long-held theories in medicine.

One of these is the danger that athletics, if taken in large amounts, can lead to the development of the dreaded "athletic heart." The athletic heart, according to Dr. Dale Groom, does not exist and he has the Tarahumara Indians to prove it. He explains why, in a long report on the distance-running activities of the Tarahumara, reprinted in the *American Heart Journal*. For the Tarahumara, running is the principal sport. It is at the same time his livelihood, his recreation, and his criterion for success, since he hunts deer by the simple method of running after him relentlessly for a couple of days until the animal drops from exhaustion. He also catches wild turkeys by pursuing them until they can no longer rise from the ground in flight.

At play, he does even more prodigious feats. His "kickball games," played by teams of men kicking a wooden ball about the size of a tennis ball carved by a machete, extend for distances up to 150 miles. And this is no relay, each man runs the route.

The Indians examined by Groom were all lean and fit (what else?) and had almost no body fat. These men with a lifetime of prodigious endurance activity all had normal-sized hearts on x-rays and normal electrocardiograms. Groom could find no instance where anyone had dropped dead or became fatally ill from any of these almost interminable running sessions.

"Obviously, more questions than answers have been raised by this work," writes Groom. Where, for instance, do the Tarahumara get the 11,000 calories needed for the hundred

mile race? Physiologists had already established that this is beyond the limit that can be expended by the body in a 24-hour period. "Have the Tarahumaras," asks Groom, "received a special dispensation from some of the human limitations known to us?" If they have, I suspect it is because these limitations are artificial and have been set up by our imperfect image of what man can and cannot do. This physical image carries the imperfections of the spiritual potential of man offered to us before the New Theology.

Quite ordinary men, who would be surprised to be called athletes, have taken to running 25 and even 50 miles at a clip—and on Earth Day, 241 normal human beings spent upward to five hours running the marathon distance of 26 miles, 380 yards, around Central Park. With them, as with the Tarahumaras (to the amazement of the physicians), the end point of endurance is not heart symptoms or shortness of breath, but leg and muscle pains.

This modest start in Central Park echoes the findings of centuries of custom and competition in the Mexican mountains. "The phenomenal feats of these primitive Indians," concludes Dr. Groom, "afford convincing evidence that most of us brought up in this sedentary comfortable civilization of today actually develop and use only a fraction of our cardiac reserve."

We are about to come full circle. Man, who originally lived or died on the basis of his bodily skills, is faced with this same decision again. His life expectancy—that of living each day at the top of his powers rather than longevity—depends on getting the utmost out of his body. Eat, drink, and be merry for tomorrow you die would be okay if it were true. It isn't. The truth is—eat, drink, and be merry and tomorrow you're gross. And gross, unfortunately, in every dimension, just as James said.

Anyone for an 80-mile kickball game?

George A. Sheehan, M.D.

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The Unwanted Child & Birth Control

Ten thousand battered children—a growing medical problem?

In his daily practice the physician witnesses the human suffering caused by uncontrolled fertility. Perhaps one of its most tragic effects is the unwanted child, who so often experiences parental rejection. The rejected child in a family may be neglected, nagged and severely punished. Sometimes he is criminally abused. Child abuse is common enough to have become a separate clinical entity: the "battered child" syndrome. Reliable statistics are difficult to obtain, but it has been estimated that in this country alone roughly 10,000 children are "battered" per year, and their number may be increasing.

A revealing picture of child abuse patterns is

provided by one study of the American Humane Society. More than half of the 662 children involved (all reported in newspapers within a single year) were less than 4 years of age. One fourth of the battered youngsters died; most of these deaths were of children less than 2 years of age. Fathers were more often guilty of child abuse than mothers, but sometimes both parents participated. The study indicated that battered children are not limited to any particular socioeconomic stratum.

***For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative.** Explored in the forthcoming issues will be the history of birth control, the influence of poverty, ethnic factors and marital status, its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain^{1,2} leading to this conclusion, and one³ in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll¹ was about sevenfold, while Sartwell and associates² in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of

them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives. An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov.) 1969.

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TRANSACTIONS

1971 House of Delegates

205th ANNUAL MEETING

The Medical Society of New Jersey

May 15-18, 1971



President, Emanuel Satulsky and son, Lewis.



Treasurer, Samuel Lloyd and Mrs. Lloyd.



Incoming President, Vernon Davis and Mrs. Davis.



Secretary, Louis Albright and Mrs. Albright.

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ANNUAL REPORTS

President

Emanuel M. Satulsky, M.D., Elizabeth

(Reference Committee "A")

The annual report of the President of The Medical Society of New Jersey is actually a factual accounting of his stewardship. It has been a great honor and privilege to serve as the one hundred and seventy-eighth president of this honorable Society, and I am truly grateful for the trust and confidence that you reposed in me. As I assumed office in May 1970 I pledged you my constant and sincere efforts to maintain and uphold the dignity of our Society and to promote its welfare and objectives. I have kept that pledge to the best of my ability, and I trust that in the discharge of my duties and multitudinous responsibilities you have found me honorable and just.

1970 was a year replete with problems. Many times during this term of office I have been grateful for the years of training and experience gained on the Judicial Council, the Board of Trustees, and the presidential offices, which enabled me more fully to meet and cope with these problems. My first objective was to achieve stability and continuity, followed by constant efforts to keep apace on the state and national levels, to study problems as they evolved, and to prepare for others prior to their onslaught. None of these accomplishments would have been possible without the dedicated, efficient, and devoted efforts of our administrative staff and all those who served so selflessly on the numerous councils and committees within our organizational structure. They have inspired me and have made me more fully aware of the extent of our indebtedness to them. I shall never cease to be grateful to all these talented and efficient people.

This has been a challenging, fascinating, and enriching year for me but it has passed much too quickly. Many of my hopes and aspirations have not been fulfilled, many projects remain uncompleted and many discussions still unresolved. There have been, however, many worthy accomplishments and definite satisfactions, many hopes have been achieved and many fears allayed. I am pleased with our continuing progress but do not wish to appear as vain as the flea riding on the axle of a speeding chariot who turned to his companions and said, "Lo, what a mighty dust we have raised."

As your president, and as an elected member of our AMA delegation, I have attended the annual and interim sessions of the AMA in Chicago and Boston, have participated in the deliberations of our delegation and have presented some of our views, opinions, and proposals before the appropriate reference committees. It was a rare honor and privilege for me to visit and participate in the annual meetings of the Medical Societies of Pennsylvania, New York, Delaware, and Maryland, where I had the opportunity to address their delegates and to observe their problems and the manner in which they proposed to solve them. In all instances I was received with great friendliness and respect and was impressed with the high esteem in which The Medical Society of New Jersey is held by these neighboring states.

It was a source of great satisfaction to me to be able to visit many of our component societies at their business meetings and social functions. I am truly grateful for the genuine

hospitality and courtesy with which I was constantly received, and I sincerely regret the rare occasion when I was unable to accept an invitation because of a long-standing previous commitment. My presentations at such meetings were invariably received with great interest as I attempted to review and discuss the problems of organized medicine and my concepts of its future role, the functions and activities of The Medical Society of New Jersey and my plea for a more active and cooperative spirit among its members. We have made an earnest effort to improve communication among the component societies. *The Journal*, the *Membership News Letter*, the distribution of the minutes of the Board of Trustees, special news releases, the bi-annual meetings with county officers and the Board of Trustees—all these were continuing efforts to keep the membership abreast of all developments and decisions. We became aware of distinct problems of certain specialty groups and have exerted every reasonable effort to assist them in reaching a solution. On several occasions their representatives were invited to meet with the Board of Trustees to present their problems and we have assigned a member of the Board to aid and properly assist them.

I have brought to the attention of the county presidents and the Board of Trustees that a Trustee is elected as a representative of a Judicial District and not from an individual or particular county. He should be invited to meetings of the component societies within the district and should be available for consultation and guidance at all times. I would urge and recommend that each component society study and cooperate in the functioning of the legislative key-man system to make it a more efficient and responsive mechanism attuned to the problems we must attempt to solve with its help.

During this year I served as a member of the Board of Trustees of Blue Shield and its Fee Review Committee and participated in many discussions concerned with developing new procedures to meet the many demands for

change. We have met on several occasions with official representatives of the Academy of Medicine of New Jersey to define more precisely our relationship and cooperative efforts in continuing medical education. The president of the Academy has been invited to make a short presentation at the Annual Meeting. We have consulted with the Deans and representatives of the medical schools to discuss problems relating to the Medical Student Loan Fund and have consistently supported both schools in their efforts and plans to provide outstanding and innovative programs. As your president, I appeared before the Board of Trustees of the New Jersey College of Medicine and Dentistry and the Mayor of Newark to urge the development and expansion of that school and other schools in New Jersey and issued a press release which was sent to the governor and legislators regarding our sentiments and convictions in this regard.

The activities during a president's year are interesting and extremely diversified. We of the Society have continued to play an active role in discussions and negotiations with the Department of Institutions and Agencies and the Prudential Insurance Company regarding procedures, fees, and utilization in the Medicaid and Medicare programs. Our relationship with these organizations has been most cordial, cooperative, and productive. We reactivated a closer liaison with the New Jersey Bar Association and have also presented recommendations from the House of Delegates at conferences with the Judiciary and Bar. We also maintained a continuing interest in federal and state legislation and made personal appearances before New Jersey legislative commissions to express our views and convictions particularly in regard to S-2015 and S-2088. A study of the comprehensive report of the Council on Legislation will reveal the detailed analyses involved and the outstanding legislative results achieved during this year.

As your president I attended a Regional Program on Peer Review and Utilization spon-

sored by the Council on Medical Services of the AMA in Washington, D.C. and returned there recently to discuss the proposed Medicare Bill and to participate in a political-action workshop sponsored by AMPAC and the AMA. Ahead lie the National Congress on the Socio-Economics of Health Care in Las Vegas, the Annual Meeting of Medical Assistants Association in Atlantic City, a meeting to discuss the chiropractic problem, several meetings with component societies, and other meetings and conferences at which The Medical Society of New Jersey will be represented and its views expounded.

I have appointed a committee to investigate and study the future relationship between our Society and politics. In addition, a vital committee on Long-Range Planning and Development has been appointed with a charge to study in depth the foundation concept, utilization and peer review mechanisms and guidelines, national health insurance proposals and the structure and organization of this Society. The committee which was appointed to establish the Physician's Relief Fund has submitted its report with definitive proposals and recommendations to the Board of Trustees and is prepared to function as soon as the House of Delegates indicates its approval. I have tried to respond promptly and with vigor in the press and by personal communication against unwarranted criticism

and condemnation of our profession by certain critics.

This has been a kaleidoscopic review of commitments, travels, council and committee meetings, responsibilities, and duties almost beyond count. Included in the problems being surveyed are: manpower—medical and allied health personnel, medical education, continuing education, delivery of health care, peer review and utilization, medical malpractice insurance, renovation of our present headquarters building, and many other important subjects. I would urge that you examine and consider the splendid work of your other officers, councils, and committees in the appropriate Annual Reports. I have made an effort not to be over-detailed and not to duplicate items referred to in other reports except in a general way.

It has been a cherished privilege to serve as the President of The Medical Society of New Jersey. You have given me an opportunity to repay a portion of the debt I owe to this noble profession. I shall always be grateful to you for permitting me to extend the work of my illustrious predecessors and I sincerely hope that you will judge my term in office one of real worth and accomplishment.

Approved (page Tr 130)



President Satulsky—Farewell Address to the House.

Secretary

Louis F. Albright, M.D., Spring Lake
(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the annual meeting of the American Medical Association in Chicago and the clinical meeting in Boston, Massachusetts—serving in a dual role as MSNJ Secretary and an AMA Alternate Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(As of December 31, 1970)

Active:	Paid	6,711	
	Exempt	497	7,208*

Associate:	Paid	528	
	Exempt	30	558*

State Emeritus			248
State Honorary			8
New and Reinstated Members:			
	Active	138	
	Associate	312	450

Transfers within the state			25
Transfers out-of-state and resignations			71
Members deceased			113
Members dropped:			
	Active (non-payment of dues)	47	
	(N. J. licensure revoked) ...	1	
	Associate (non-payment of dues)	11	59

*Adjusted for transfers out-of-state, resignations, and deaths.

AMA MEMBERSHIP

A total of 6,124 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total seven delegates—one for each thousand members, or fraction thereof.

MEMBERSHIP DIRECTORY

In October 1970, the completion of the 1970-71 edition of the *Membership Directory* was announced. Distribution to the entire membership was made the same month.

Basically the new *Directory* embodies the same features as that of the 1968-69 edition, which include:

The supplement section—available only in copies prepared for members—has had added to it Guides for Physician-Hospital Relationships in New Jersey. It also contains the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Practitioners, and a list of Poison Control Centers in New Jersey.

Again, an expression of gratitude is in order for the cooperation received from the membership in assisting us to produce this *Directory*.

Approved (page Tr 130)

Treasurer

Samuel J. Lloyd, M.D., Trenton

(Reference Committee "B")

This 1971 interim report of your Treasurer has been prepared from the books and records of The Medical Society of New Jersey.

The Comparative Balance Sheet is presented as of 30 April 1971 and 30 April 1970 without audit or opinion, for the reason that the current fiscal year of the Society does not end until 31 May 1971. Audited figures and a report of audit will be submitted for the year ended 31 May 1971 at a subsequent date.

The Comparative Statement of Revenue, Expenditures, and General Surplus Unappropriated presents the transactions of the Society for the eleven-month periods ended 30 April 1971 and 30 April 1970.

Revenues have been checked, by the Society's

independent accountants, in full for the period and disbursements test-checked to supporting approved vouchers. The cash balances at 30 April 1971 were reconciled with the bank statements but were not confirmed directly with the depositories. Revenue from counties for dues' assessments was checked in detail to reports on file, but was not confirmed with County Treasurers at this time. Investments were not physically examined or confirmed.

These interim statements have been prepared in a form similar to the annual audit report in order to show in greater detail the assets, liabilities and fund balances, operating revenue, and expenditures of the Society, in conformity with Resolution #28 approved by the 1968 House of Delegates under the heading "Annual Financial Report."

GENERAL FUND COMPARATIVE BALANCE SHEET

ASSETS	30 April	
	1971	1970
Cash (Page Tr 13)	\$104,742.37	\$ 66,845.37
Certificates of deposit (Page Tr 13)	335,000.00	45,000.00
Investments—at cost (Page Tr 14)	170,433.00	425,466.62
Accounts receivable	9,513.95	7,030.16
Inventories:		
Maternal Service Record Books (contra)	2,361.60	3,115.31
"The Healing Art" books (contra)	8,474.80	8,506.96
Land, buildings, and equipment (contra)	166,255.66	165,215.36
Accrued interest and other assets	5,803.45	8,569.11
	<u>\$802,584.83</u>	<u>\$729,748.89</u>
LIABILITIES, SPECIAL FUNDS AND GENERAL SURPLUS UNAPPROPRIATED	30 April	
	1971	1970
Liabilities:		
Unexpended budget appropriations (Page Tr 10)	\$101,595.49	\$ 88,356.20
American Medical Association (Page Tr 12)	66,880.00	280.00
Library of Academy of Medicine (Page Tr 12)	95.00	25.00
Journal Publication	—	5,000.00
Other current liabilities	4,375.89	3,269.74
Special Funds:		
Provision for Medical Journal losses	10,000.00	10,000.00
Assessments deferred to subsequent fiscal year (Page Tr 12)	218,134.58	208,478.38
Membership Directory	1,115.64	3,077.00
Annual Meeting	21,603.99	24,570.57
"The Healing Art" books (contra)	8,474.80	8,506.96
House Restoration and Replacement	39.24	6,960.74
Maternal Service Record Books (contra)	2,361.60	3,115.31
Land, buildings and equipment (contra)	166,255.66	165,215.36
General surplus unappropriated (Page Tr 10)	201,652.94	202,893.63
	<u>\$802,584.83</u>	<u>\$729,748.89</u>

**COMPARATIVE STATEMENT OF REVENUE,
EXPENDITURES AND GENERAL SURPLUS UNAPPROPRIATED**

	<i>For the Eleven Months Ended 30 April</i>	
	<i>1971</i>	<i>1970</i>
Revenue:		
Assessments earned (Page Tr 12)	\$389,612.84	\$357,175.09
Income on Savings Accounts (Page Tr 13)	4,190.76	2,701.26
Income from Investments (Page Tr 14)	15,882.35	18,301.78
Maternal Service Record Book Sales	688.80	673.09
Miscellaneous Income	64.48	69.34
Total Revenue	\$410,439.23	\$378,920.56
Less Approved Budget for Year (below)	407,067.00	373,576.00
Excess of Revenue over Approved Budget	\$ 3,372.23	5,344.56
Deduct Medical Journal deficit (Page Tr 11)	29,699.25	24,811.62
Net Deficit	\$ 26,327.02	\$ 19,467.06
Transfers and Surplus Adjustments—net	\$ (233.97)	\$ 198.78
	\$ 26,560.99	\$ 19,268.28
General Surplus Unappropriated:		
Balance June 1	\$228,213.93	\$222,161.91
Balance April 30	<u>\$201,652.94</u>	<u>\$202,893.63</u>

STATEMENT OF EXPENDITURES—GENERAL FUND

For the Eleven Months Ended 30 April 1971

	<i>Adopted Budget</i>	<i>Total Expended</i>	<i>Balance Unexpended</i>
Administrative and Executive:			
Executive Salaries	\$ 66,710.40	\$ 61,411.14	\$ 5,299.26
General Staff Salaries	113,277.24	97,081.72	16,195.51
General Executive Office Expenses	17,000.0	14,429.00	2,571.00
Executive Travel	3,200.00	2,248.57	951.43
House Maintenance	19,000.00	16,895.97	2,104.03
Treasurer	6,600.00	5,644.25	955.75
Finance and Budget Committee	75.00	4.58	70.42
Secretary	400.00	49.90	350.10
Salary Taxes	8,749.36	7,427.80	1,321.56
Insurance	10,200.00	8,986.07	1,213.93
House Reserve	6,500.00	2,269.59	4,230.41
MSNJ Pension Plan	1,400.00	602.39	797.61
Welfare :			
Legislation Council	8,400.00	5,097.47	3,302.53
Public Health Council	2,600.00	1,080.44	1,519.56
Public Relations Council	6,800.00	4,263.86	2,536.14
Medical Services Council	700.00	176.62	523.38
Mental Health Council	1,400.00	351.20	1,048.80
Special:			
President and Presidential Officers	15,000.00	12,119.44	2,880.56
AMA Delegates	12,650.00	8,983.87	3,666.13
Woman's Auxiliary	4,805.00	3,921.78	883.22
Medical Education Committee	35,200.00	17,505.43	17,694.57
Conference Groups	500.00	63.71	436.29
Membership Directory	14,000.00	14,000.00	—
Emergency Medical Care Committee	300.00	130.40	169.60
Credentials and Membership Committee	600.00	716.84	(116.84)
Archives and History	100.00	—	100.00
Project Hope—Vietnam	6,000.00	1,000.00	5,000.00
Medical Defense and Insurance Com.	500.00	241.47	258.53
Other:			
Board of Trustees	6,100.00	2,487.85	3,612.15
Contingent	10,000.00	4,489.87	5,510.13
Judicial Council	500.00	95.34	404.66
Legal	7,300.00	5,750.00	1,550.00
Health Facilities Planning Council	5,000.00	5,000.00	—
Medical Student Loan Fund	12,000.00	—	12,000.00
Reimbursement for Rep. to Meetings	3,500.00	944.93	2,555.07
Total Budget Expenditures ..	\$407,067.00	\$305,471.51	\$101,595.49

COMPARATIVE STATEMENT OF REVENUE AND EXPENDITURES—MEDICAL JOURNAL

	For the Eleven Months Ended 30 April	
	1971	1970
Revenue:		
Advertising:		
State Medical Journal Advertising Bureau	\$ 39,763.63	\$ 36,265.57
Local	11,504.99	11,473.09
Cooperative Rebate	2,787.80	2,172.86
Classified	282.10	454.80
Subscriptions and Extra Copies	1,442.31	1,624.36
Illustrations	411.00	606.16
Reprints—net	910.70	1,132.85
Total Revenue	<u>\$ 57,102.53</u>	<u>\$ 53,729.69</u>
Expenditures:		
Publication	\$ 59,234.93	\$ 52,283.45
Salaries	15,407.35	14,120.00
Advertising Manager's Commission	4,705.49	4,892.62
Local Commissions	3,775.08	2,886.15
Discounts	900.66	898.32
Administrative Expenses	1,014.81	1,154.41
Payroll Taxes	876.66	830.40
Insurance	275.28	338.55
Travel	87.12	216.63
Illustration Expense	459.08	898.72
Office Expenses	65.32	22.06
Total Expenditures	<u>\$ 86,801.78</u>	<u>\$ 78,541.31</u>
Excess of Expenditures over Revenue	<u>\$ 29,699.25</u>	<u>\$ 24,811.62</u>

MEDICAL STUDENT LOAN FUND COMPARATIVE BALANCE SHEET

	30 April	
ASSETS	1971	1970
Cash (Page Tr 13)	\$ 24,844.22	\$ 38,343.08
Certificates of Deposit (Page Tr 14)	130,000.00	—
Investments—at cost	—	111,728.70
Notes Receivable—secured by Life Insurance Policies	199,811.50	190,369.00
Accrued Interest on Investments	363.00	1,044.33
Fund Balance	<u>\$355,018.72</u>	<u>\$341,485.11</u>

Note: The fund balance includes \$6,562.00 designated as the A. Barker Kump Memorial Grant and \$5,064.17 designated as the Joseph E. Mott Memorial Grant.

MEDICAL STUDENT LOAN FUND COMPARATIVE STATEMENT OF REVENUE AND FUND BALANCE

	30 April	
	1971	1970
Revenue:		
Contributions:		
General	\$ 3,107.30	\$ 3,484.52
Budget Appropriation from General Fund	—	5,000.00
A. Barker Kump Memorial	250.00	—
Joseph E. Mott Memorial	34.17	—
Income from Certificates of Deposit and Investments (Page Tr 14)	7,408.30	6,473.85
Interest on Savings Accounts (Page Tr 13)	678.88	1,273.03
Interest on Notes Receivable	234.31	252.39
Total Revenue	<u>\$ 11,712.96</u>	<u>\$ 16,483.79</u>
Bad Debt Recovered	50.00	140.00
Net Revenue	<u>\$ 11,762.96</u>	<u>\$ 16,623.79</u>
Fund Balance:		
June 1	343,255.76	324,861.32
April 30	<u>\$355,018.72</u>	<u>\$341,485.11</u>

SCHEDULE OF STATE ASSESSMENTS COLLECTED
For the Eleven Months Ended 30 April 1971

County	1971 Dues	1970 Dues	Net State Assessments
Atlantic	\$ 8,910.00	\$ 430.88	\$ 9,340.88
Bergen	46,750.00	1,026.87	47,776.87
Burlington	9,900.00	330.05	10,230.05
Camden	22,550.00	458.40	23,008.40
Cape May	2,035.00		2,035.00
Cumberland	5,115.00	110.00	5,225.00
Essex	78,870.00	2,988.51	81,858.51
Gloucester	5,115.00	110.02	5,225.02
Hudson	25,025.00	1,503.36	26,528.36
Hunterdon	2,420.00		2,420.00
Mercer	18,260.00	4,354.23	22,614.23
Middlesex	22,220.00	412.55	22,632.55
Monmouth	19,690.00	2,640.09	22,330.09
Morris	20,900.00	705.93	21,605.93
Ocean	7,095.00	971.71	8,066.71
Passaic	32,285.00	504.22	32,789.22
Salem	2,200.00	55.00	2,255.00
Somerset	4,785.00	788.35	5,573.35
Sussex	2,695.00	238.34	2,933.34
Union	34,925.00	403.36	35,328.36
Warren	2,200.00	73.35	2,273.35
Total	<u>\$373,945.00</u>	<u>\$18,105.22</u>	<u>\$393,505.22</u>

RECONCILIATION OF STATE ASSESSMENT ACCOUNT
For the Eleven Months Ended 30 April 1971

Unearned Assessments, 31 May 1970	\$215,697.20
Collections, net of refunds:	
Members and Associate Dues	392,050.22
	<u>\$607,747.42</u>
Less 1971 assessments applicable to year ending	
31 May 1972 (7/12 of \$373,945.00)	218,134.58
Earned assessments for the period ended 30 April 1971	<u>\$389,612.84</u>

SCHEDULE OF SPECIAL ASSESSMENTS COLLECTED
For the Eleven Months Ended 30 April 1971

County	American Medical Association Dues	Library of Academy of Medicine Assessments
Atlantic	\$ 15,900.00	\$ 5.00
Bergen	55,690.00	
Burlington	16,230.00	
Camden	39,740.00	
Cape May	3,300.00	
Cumberland	8,130.00	
Essex	117,490.00	
Gloucester	9,020.00	
Hudson	33,140.00	
Hunterdon	3,080.00	
Mercer	35,780.00	5.00
Middlesex	35,910.00	
Monmouth	21,290.00	
Morris	32,545.00	
Ocean	12,100.00	
Passaic	32,070.00	
Salem	4,360.00	
Somerset	8,110.00	
Sussex	4,140.00	
Union	55,930.00	5.00
Warren	3,850.00	
Total	<u>\$547,805.00</u>	<u>\$15.00</u>

RECONCILIATION OF SPECIAL ASSESSMENT ACCOUNTS
For the Eleven Months Ended 30 April 1971

	<i>American Medical Association</i>	<i>Library of Academy of Medicine</i>
Balance Payable, 31 May 1970	\$ 490.00	\$ 80.00
Assessment collected per above	547,805.00	15.00
	<u>\$548,295.00</u>	<u>\$ 95.00</u>
Remitted to Organizations	481,415.00	—
	<u>481,415.00</u>	<u>—</u>
Balance Payable, 30 April 1971	<u>\$ 66,880.00</u>	<u>\$ 95.00</u>

ANALYSIS OF CASH, SAVINGS ACCOUNTS AND INCOME THEREON
30 April 1971

General Fund:

New Jersey National Bank:
Treasurer's General Checking
Executive Account Checking
Office Petty Cash Fund

\$ 89,742.37
14,500.00
500.00

Total

\$104,742.37

Medical Student Loan Fund:

New Jersey National Bank:
Treasurer's Checking Account
Savings Account

<i>Balances 30 April 1971</i>	<i>Rate of Interest</i>	<i>Interest Income</i>
\$ 9,844.22		
15,000.00	4½%	\$ 678.88
<u>\$ 24,844.22</u>		<u>\$ 678.88</u>

Total

ANALYSIS OF CERTIFICATES OF DEPOSIT AND INCOME THEREON

	<i>Date Due</i>	<i>Balances 30 April 1971</i>	<i>Rate of Interest</i>	<i>Interest Income</i>
General Fund:				
New Jersey National Bank:				
Certificate Number				
56213		\$15,000.00	5%	\$ 752.32
562	5/21/71	35,000.00	5%	340.37
66367	5/26/71	30,000.00	5%	263.01
C570	6/08/71	35,000.00	4%	203.29
C587	7/19/71	35,000.00	4%	164.93
66392	6/23/71	30,000.00	5%	147.94
C590	8/07/71	35,000.00	4%	138.08
66397	7/01/71	30,000.00	5%	119.18
C602	9/08/71	30,000.00	4%	72.33
66341	7/21/71	30,000.00	5%	414.31
First National Bank of Spring Lake:				
Number 1242		15,000.00	5½%	825.00
South Jersey National Bank:				
Number 2101		15,000.00	5%	750.00
		<u>\$335,000.00</u>		<u>\$4,190.76</u>

ANALYSIS OF CERTIFICATES OF DEPOSIT AND INCOME THEREON

	<i>Balances 30 April 1971</i>	<i>Rate of Interest</i>	<i>Interest Income</i>
Medical Student Loan Fund:			
Certificate Number			
66334	\$ 30,000.00	5%	\$ 426.64
66385	20,000.00	5%	117.81
66393	40,000.00	5%	158.90
71034	40,000.00	5%	49.31
Total	<u>\$130,000.00</u>		
Income from Investments Redeemed during the period			6,655.64
Total Interest from Investments			<u>\$7,408.30</u>

SCHEDULE OF INVESTMENTS AND INCOME EARNED 30 April 1971

<i>Description</i>	<i>Yield to Maturity</i>	<i>Cost</i>	<i>Maturity Value</i>	<i>Interest Income</i>
General Fund:				
Southern Railway Equipment Trust				
Certificates, due 11/1/72	6.125	\$ 19,465.00	\$ 20,000.00	\$ 1,122.92
Great Northern Railway Equipment				
Trust Certificates, due 3/1/73	6.00	20,000.00	20,000.00	1,100.00
Export-Import Bank Debentures				
due 4/20/73	6.15	20,000.00	20,000.00	1,127.50
Federal Intermediate Credit Bank				
Debentures, due 7/1/71	7.10	50,125.00	50,000.00	2,042.46
Federal Intermediate Credit Bank				
Debentures, due 10/4/71	5.30	20,000.00	20,000.00	264.27
Union Pacific Railroad Equipment				
Trust Certificates, due 2/1/74	7.00	20,843.00	20,000.00	181.93
Federal National Mortgage				
Association, due 6/10/75	5.25	20,000.00	20,000.00	48.90
Total Investments		<u>\$170,433.00</u>	<u>\$170,000.00</u>	5,887.98
Income from investments redeemed and sold during the period				9,994.37
Total Interest from Investments				<u>\$15,882.35</u>

Approved, with commendation to the Treasurer and the added observation "that the Executive Offices need additional facilities, and that an assessment would be required in future years to pay for the cost thereof." (page Tr 133)



Opening Session of House of Delegates.

Board of Trustees

Thomas C. DeCecio, M.D., Chairman, Cliffside Park
(Reference Committee "A")

Full minutes of the meetings of the Board of Trustees have been distributed regularly to component societies, and summaries of the Board's significant actions have been highlighted in *The Journal*. Therefore, as has been the custom, this report of the Board of Trustees will cover only those items of particular import that are not reflected elsewhere in the individual reports of councils and committees.

Since its last report to the House, a total of 10 meetings of the Board will have been held. Board attendance at these meetings was excellent.

Dr. George E. Barbour of Somerville was elected by the Board to serve as its Secretary during the past year. Special commendation is due him for his conscientious performance in processing all Board correspondence and meeting notices.

The Board has dealt with matters of all kinds arising out of its responsibilities or brought to its attention, including correspondence and resolutions from members, component societies, the American Medical Association, and outside organizations. It has appointed representatives to local, state and national meetings of concern to MSNJ; acted on reports and recommendations of the Society's councils and committees; and cooperated with allied organizations and various departments of state government.

The Board recorded its profound grief—as set forth in individual resolutions—in the deaths during the past year of David B. Allman, M.D., who served as President of the American Medical Association from 1957-1958, and Louis S. Wegryn, M.D., who served as the 170th President of The Medical Society of New Jersey. The memorial resolutions adopted by the Board will be submitted as the

first order of business at the 1971 House of Delegates for concurrence.

The Board of Trustees will have two more meetings before the first session of the House of Delegates. The items from those meetings which must be directed to your attention will be the subject of a supplemental report.

Approved (page Tr 130)

COMMITTEE ON LONG RANGE PLANNING AND DEVELOPMENT (Reference Committee "A")

At the request of the President, the Board of Trustees authorized the establishment of a Committee on Long Range Planning and Development. The charge to this Committee is to look to the future to devise policies and strategies which will improve the structure and operations of MSNJ. Other areas that may be explored by the Committee include: investigation of the foundation concept of medicine; consideration as to whether or not MSNJ's judicial mechanism should be separated from problems of fees and utilization; consideration of whether or not the Society should establish a disciplinary mechanism to fit between the judicial mechanism and the revised State Board of Medical Examiners; and administrative services.

Approved (page Tr 130)

FIRST-AID STATION FOR LEGISLATORS (Reference Committee "A")

The Board of Trustees has been investigating the feasibility and desirability of making arrangements with the proper officers of the New Jersey legislature for members of the Society to man the first-aid station in the State House on days when the legislature is in session as a service to the legislators. The response of leaders of the legislature to the proposal has been favorable.

Therefore, at its meeting on 21 February, the Board of Trustees directed that each component society be asked (a) to indicate its reaction to the proposal, and (b) to supply a list of its members who would be willing to serve as physicians-in-charge of the first-aid station on session days (Mondays and Thursdays) through the legislative year. It is contemplated that no member would be called upon to serve more than one day in the year.

Approved (page Tr 130)

JOINT CONFERENCE WITH PRESIDENTS AND
PRESIDENTS-ELECT OF COMPONENT SOCIETIES
(Reference Committee "A")

The Board continued the precedent of sponsoring, in the fall and spring, informal conferences for presidents and presidents-elect of component societies. The first conference was held on Sunday, 18 October 1970. A total of 29 presidents and/or presidents-elect represented 17 component societies. The second conference was held on Sunday, 21 March 1971. A total of 27 presidents and/or presidents-elect represented 18 component societies.

Underlying the conference is the realization that since component societies have many common problems to resolve and similar situations to deal with, it would be informative and profitable for presidents and presidents-elect to learn how other component societies are proceeding and the experiences that have been developed.

The subsequent meeting with the Board, which follows the informal meeting of presidents and presidents-elect, is intended to provide the conferees with an appreciation of the scope and operations of the Board of Trustees and to afford the opportunity for exchange of constructive ideas.

It is the opinion of the conferees that these meetings continue to be successful and profitable and should be continued.

Approved (page Tr 130)

NATIONAL BICENTENNIAL CELEBRATION
(Reference Committee "A")

A Committee on National Bicentennial Celebration was established by the Board to investigate the possibility of the Society's participation in the National Bicentennial Celebration in 1976. At its meeting on 15 November 1970, at the suggestion of the Committee, the Board unanimously agreed that MSNJ should officially participate in the celebration.

Approved (page Tr 130)

THE ACTIVE PRACTICE OF MEDICINE
(Reference Committee "A")

The Secretary of The Medical Society of New Jersey received a request from the Camden County Medical Society for a definition of the term, "the active practice of medicine" as it is used in Article IV, Section 6 of the MSNJ Constitution, dealing with "Emeritus Members." The Secretary supplied the following as the definition that he considers applicable and accurate:

"The active practice of medicine consists of the earnings of one's livelihood by the performance of such work and the rendering of such services as require the knowledge and/or skills proper only to members of the medical profession."

The Board subsequently concurred in the Secretary's definition.

Approved (page Tr 130)

AD HOC COMMITTEE ON STATEWIDE AUTOMATED BOOKKEEPING, ACCOUNTING, AND BILLING SYSTEM
(Reference Committee "B")

At the 1970 Annual Meeting, the House of Delegates adopted, as amended, Resolution #4 (Statewide Automated Bookkeeping, Accounting, and Billing System). The "resolved" portion of that resolution reads as follows:

RESOLVED, that The Medical Society of New Jersey investigate an automated modern system of bookkeeping, accounting, and billing, and make the advantages of such system available to all component societies on a fair basis of cost, if found feasible,

and that the Board of Trustees be empowered to put such automated system into effect.

At its reorganization meeting on 20 May 1970, the Board was informed that preliminary investigations had already been made by the Business Manager. Thereupon, the Board directed that a committee composed of the Treasurer, the Secretary, the Chairman of the Committee on Finance and Budget and the Business Manager be established to review developments to date and to continue to investigate the procedures required to implement such systems.

At the 21 March 1971 meeting of the Board of Trustees, the Committee presented a detailed report for the Board's consideration. Items which the Board considered dealt with: (1) results of the survey made of component medical societies; (2) review of three quotations obtained from data processing firms; (3) review outline of MSNJ procedures in processing county, state, and AMA dues; and (4) review outline of MSNJ expected expenditures and revenue to arrive at a break-even point.

The survey results, showing the county and membership are as follows:

County	Yes	County	No
Bergen	946	Burlington	206
Camden	454	Cape May	48
Essex	1673	Cumberland	107
Mercer	521	Gloucester	94
Monmouth	445	Hudson	596
Morris	429	Hunterdon	59
Ocean	147	Passaic	663
		Salem	42
Seven—Total	4,615	Somerset	142
		Nine—Total	1,957

County	Non-Committal	County	No Reply
Union	716	Atlantic	197
		Middlesex	446
One—Total	716	Sussex	55
		Warren	47
		Four—Total	745

8,033 Total Membership as above—28 February 1971

The estimated expenditures and revenue for the statewide billing system are as follows:

Estimated Expenditures:

(1) Data Processing System and Form design and printing	\$5,500.00
(2) Additional Staff Member	6,000.00
(3) First Class Postage—(12,000 @ \$.17)	2,040.00
(4) Contingent	1,000.00
	<hr/> \$14,540.00

Estimated Revenue:

** (2) AMA 1% Rebate	\$ 4,950.00
*** (2) Component Societies per capita share of cost	9,590.00
	<hr/> \$14,540.00

*Postage is reflected on the basis of 8,000 members, postage both ways, 50% second billing.

**Based on 1970 AMA 1% rebate on 5,057 members @ \$.75 or \$3,792.75 reduced to allow for anticipated loss in AMA members in 1971—4500 @ \$1.10 or \$4,950.00

***Based on 8,000 members, per capita share of approximately \$1.20 is estimated. Based on 7,260 paying members, per capita share of approximately \$1.32 is estimated.

At the meeting on 21 March 1971, the Board agreed that the results of the Committee's investigation should be reported to the 1971 House of Delegates.

Approved. The House also approved a second recommendation of the Reference Committee "that a further survey of counties be taken informing them of the cost factors involved and of the advantages accruing from such a system before final action is taken by the Board of Trustees. (page Tr 132)

PHYSICIAN'S RELIEF FUND (Reference Committee "B")

At the 1970 Annual Meeting, Reference Committee "B" recommended that Resolution #16 (Physicians' Welfare Fund) be disapproved, and the House adopted that recommendation. However, the Reference Committee agreed with the intent of the resolution and suggested that the Board of Trustees appoint a Committee to define the terms of the administration of such a fund and that it be financed annually by a dollar per capita taken from surplus. The House approved the suggestion of the Reference Committee.

The Board of Trustees, in fulfillment of the directive of the House authorized the President to appoint a five-man committee (one from each judicial district) to investigate the

matter and report back to the Board. The President appointed the following to serve on that Committee:

Joseph J. Kline, M.D., Chairman (3rd district)
John J. Bedrick, M.D. (2nd district)
A. Guy Campo, M.D. (5th district)
Richard R. Chamberlain, M.D. (1st district)
Frederick W. Durham, M.D. (4th district)

After a series of meetings in which all aspects of the proposal and programs already operative under the aegis of other agencies were considered, the Committee submitted the following items to the Board of Trustees for consideration:

1. That a program known as the "Physicians' Relief Fund of The Medical Society of New Jersey" be established.
2. That it be administered by a committee of The Medical Society of New Jersey, similar to that of the Medical Student Loan Fund, with each judicial district represented, and with a member of the staff assigned to be responsible for the maintenance of records and for supervision of the administration of the Relief Fund.
3. That the Committee consist of five (5) members, appointed from the respective judicial districts by the Board of Trustees, and that in addition to its normal administrative powers, the Committee be authorized to appoint one or more "Fund" representatives from each of the component societies.
4. That the Committee, as its first order of business, be charged with the responsibility of drafting a statement of purpose and policy to govern the operations of the Fund, together with suggested rules and regulations concerning financing, eligibility, and bestowal and limitations of benefits—all for submission to and clearance by the Board of Trustees and/or the House of Delegates.
5. That the Fund be financed by an initial allocation determined by the Committee on Finance and Budget in an amount not to exceed \$35,000.

At its meeting on 20 December 1970, the Board of Trustees approved the establishment of a program to be known as the "Physicians' Relief Fund of The Medical Society of New Jersey." In implementation of the foregoing decision the Board proposes an amendment to the Bylaws (Chapter IX—Administrative Councils and Committees). The proposed amendment is contained in the annual report of the Committee on Revision of Constitution and Bylaws.

Approved (page Tr 133)

Tr 18

PROPOSED NATIONAL ACADEMY OF THE HEALTH PROFESSIONS FOR RESEARCH AND POLICY

(Reference Committee "D")

This resolution (Essex County) called upon The Medical Society of New Jersey to urge that in structuring the proposed National Academy of the Health Professions for Research and Policy the American Medical Association be called upon to include representatives of hospital chaplains.

The Board directed the resolution to the AMA Delegates for transmittal to the AMA. No steps toward the structuring of such Academy have been reported.

Approved (page Tr 136)

COMMITTEE ON EXTENSION TO INTERNS AND RESIDENTS OF POWER TO SIGN CERTAIN LEGAL DOCUMENTS (Reference Committee "E")

In the 1970 annual report of the Board of Trustees, it was stated that the Attorney General, acting in concern for certain welfare patients in Essex County, issued an informal opinion to the New Jersey Pharmacy Board which declared that prescriptions signed by interns and residents of the Martland Medical Center in Newark may be legally filled in retail pharmacies of the area. In all other areas of the State this privilege does not apply.

Reference Committee "E" recommended approval of the report; however, it felt that the privilege should be extended to all New Jersey hospitals. It therefore recommended that The Medical Society of New Jersey request the State Board of Medical Examiners to obtain a formal opinion from the Attorney General relevant to this matter. To date no reply has been received from the State Board of Medical Examiners.

Approved. The Reference Committee urged that further efforts be made to obtain a final opinion from the Attorney General. (page Tr 137)

MSP BOARD OF TRUSTEES—NOMINATIONS
(Reference Committee "C")

The following nominations were approved by the Board and are referred to the House of Delegates for action:

Not included in this printed list of members serving on the Board of Trustees are the following: Chairman of the Board of Trustees

of Hospital Service Plan of New Jersey, and the President of The Medical Society of New Jersey. These individuals serve during their respective terms of office of the organization indicated.

Also listed are persons who will continue membership on the Board until the expiration of their terms in the year indicated—or until their successors are elected and qualified.

Three-year term (1971-1974):

<u>Name</u>	<u>Type of Practice</u>	<u>Member of Component Society</u>
Edwin H. Albano, M.D.	Pathologist	Essex County
James T. Crowley	Businessman	---
Lloyd M. Felmly	Retired Newspaper Editor	---
John Kelly	Labor Leader	---
Samuel J. Lloyd, M.D.	Surgeon	Mercer County
Theron L. Marsh	Banker	---
Jesse McCall, M.D.	Internist	Sussex County
Rudolph C. Schretzmann, M.D.	Obstetrician	Bergen County
Charles O. Tyler, M.D.	Pediatrician	Camden County
Thomas J. White, M.D.	Internist	Hudson County

Terms Expiring 1972

<u>Terms Expiring 1972</u>	<u>Type of Practice</u>	<u>Member of Component Society</u>
Donald T. Akey, M.D.	Surgeon	Middlesex County
Robert G. Boyd	Hospital Administrator	---
Joseph A. Cox, M.D.	Anesthesiologist	Union County
Charles L. Cunniff, M.D.	Internist	Hudson County
Andrew P. Dedick, Jr., M.D.	Radiologist	Monmouth County
Warren H. Simmons, Jr.	Businessman	---
Sidney I. Simon, Ph.D.	College Professor	---
Morgan Sweeney	Labor Leader	---
Robert E. Vernon, M.D.	General Practitioner	Bergen County

Terms Expiring 1973

<u>Terms Expiring 1973</u>	<u>Type of Practice</u>	<u>Member of Component Society</u>
Edgar P. Eaton, Jr.	Businessman	---
Edwin T. Ferren, D.O.	General Practitioner	---
Mortimer J. Fox, Jr.	Businessman	---
Jerome G. Kaufman, M.D.	Internist	Essex County
Joseph M. Keating, M.D.	Obstetrician	Passaic County
Elton W. Lance, M.D.	Surgeon	Union County
Henry J. Mineur, M.D.	Internist	Union County
Stanley C. Van Ness	Lawyer	---
John F. Waters	Labor Leader	---

Approved (page Tr 134)

HEALTH CAREERS EXHIBIT
(Reference Committee "E")

Request was granted to John Scillieri, M.D. to appear before the Board at its 21 February meeting. At that meeting Doctor Scillieri reported upon the success of the dyslexia exhibit presented by MSNJ's Committee on the Conservation of Vision, Hearing, and Speech at the convention of the New Jersey Education

Association in November 1970. Because of the large attendance at the NJEA convention each year, Doctor Scillieri proposed that MSNJ sponsor a broad health careers series of exhibits in cooperation with the proper agencies in the paramedical field. The next convention of the New Jersey Education Association is scheduled to be held 4-6 November 1971, in Atlantic City.

The Board voted to approve the proposal and authorized Doctor Scillieri to implement the project within the cost limits estimated.

Approved (page Tr 137)

LEGISLATIVE APPROACH TO MALPRACTICE
(Reference Committee "E")

On the recommendation of Reference Committee "E", the 1970 House of Delegates approved Resolution #9 (Essex County) in principle. This resolution lists fourteen areas of consideration for reducing the incidence of malpractice suits. The House referred the contents of the resolution to the Joint Conference Committee of the Council on Legislation and the Committee on Medical Defense and Insurance.

The Joint Committee has been considering and dealing with the elements of the resolution item by item. Plans are under way to prepare legislation for introduction for those items that have potential for legislative action.

Approved (page Tr 137)

MEDICAL-LEGAL LIAISON COMMITTEE
(Reference Committee "E")

The following recommendations, submitted by the Society's representatives on the Liaison Committee with the New Jersey Bar Association, were approved by the Board on 20 December 1970:

1. That each county bar association and component medical society be urged to adopt a cooperation agreement. If they do not already have one or if their current agreement does not function as well as desirable, it is suggested that they utilize the format of the Morris County Agreement with such modifications as are appropriate locally.

2. That at least once a year each county bar association and the respective component medical society hold a joint social meeting.

In order to assist component societies in the implementation of the first recommendation, a copy of the *Interprofessional Code for Physicians and Attorneys* and a copy of the *Medical-Legal Cooperation Agreement* between the

Morris County Bar Association and the Morris County Medical Society were supplied to the secretaries of component societies.

Approved (page Tr 137)

OPPOSITION TO THE LEGALIZATION OF
MARIHUANA
(Reference Committee "E")

The 1970 House of Delegates (Resolution #10—Essex County called upon MSNJ to instruct its delegates to the AMA to endorse a resolution proposing that the AMA establish a policy that marihuana is a dangerous drug, that strict penalties should be imposed for its importation or sale, and opposition to its legalization should be strongly supported. A resolution (#82) was introduced and supported by New Jersey's Delegation at the AMA Annual Convention.

The AMA House, on the recommendation of the Reference Committee (H) affirmed its agreement with the intent of the resolution and referred it to the Board of Trustees and to its Committee on Alcoholism and Drug Dependence with direction that a report and recommendation for AMA policy on the use of marihuana be made to the House at the 1970 Clinical Convention.

Subsequently, at the 1970 Clinical Convention, the House voted to reaffirm the AMA's policy of opposition to the legalization of marihuana.

Approved (page Tr 137)

CRITERIA USED BY FISCAL INTERMEDIARIES IN
REVIEWING PHYSICIANS' SERVICES
(Reference Committee "F")

This resolution (Delegate from Essex County) directed The Medical Society of New Jersey to "request the carriers to call to the attention of every physician in the State any procedure or modality which has been designated by the Federal government as unacceptable for Medicare reimbursement."

A copy of that resolution was forwarded to James E. Brennan, M.D., Medical Director, Governmental Health Programs for the Prudential Insurance Company at its Millville Office.

Replying, Doctor Brennan stated:

" . . . decisions on good medical practice or useless forms of treatment are not within our right. As the government's intermediary or Part B carrier, we are obliged to review the services of physicians for evidence of over-utilization, abuse, and fraud but this information should not be voluntarily brought to the patient's attention.

"At times we may receive directives from the Social Security Administration stating that it is their determination that injections such as B₁₂ should be allowed in only certain conditions, or that a particular type of diathermy machine has been found to be 'therapeutically useless' and that such treatments should be disallowed. We realize that this circumstance could prove embarrassing to a physician and that he alone can best explain the denial to the patient. A difficult situation can arise if the carrier is queried by the beneficiary, and there is evidence that several patients were informed by well-meaning claims people that Diapulse diathermy treatments were denied because the government had found them to be useless. I assure you that we intend that this shall not occur again and we will make every effort to keep physicians informed of changes in regulations."

Approved. The Reference Committee urged the fiscal intermediaries to notify the physicians of their policy changes by direct and prompt communication. (page Tr 139)

ESTABLISHMENT OF OFFICE OF PROFESSIONAL MEDICARE LIAISON WITHIN PRUDENTIAL COMPANY

(Reference Committee "F")

This resolution (Morris County) called upon The Medical Society of New Jersey to bring about the establishment of an office of Medicare liaison within the Prudential Insurance Company. A copy of the resolution was forwarded to James E. Brennan, M.D., Medical Director, Governmental Health Programs for the Prudential Insurance Company at its Millville Office.

Doctor Brennan replied to the Board in early July 1970 and pointed out that as Medical Director of Governmental Health Programs he is assisted by Carl N. Ware, M.D., and that together it is their function to serve as liaison

individuals with concerned members of the medical profession. He added in his communication, "There should be no reason on our part for failure to aid and assist, but should a physician feel dissatisfied with our determinations, he could appeal to the Joint Medicare Claims Inquiry Committee which has been established."

Approved (page Tr 139)

INTERNSHIPS

(Reference Committee "F")

At the AMA Annual Convention the House was called upon to consider and act upon the following statements:

"After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole.

After July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education."

The MSNJ House of Delegates in May 1970 (Resolution #31—Delegate from Bergen County) recorded the Society as favoring the continuance of internships in hospitals in the communities, even though no residency programs are offered. It also directed the New Jersey AMA Delegates to resist any action on the part of the AMA to the contrary.

The New Jersey Delegation carried its opposition to the floor of the House where Dr. John F. Kustrup urged the House not to adopt the statements before it. The effort was unavailing, however, and the House, by a strong vote, adopted both statements.

Approved (page Tr 140)

MEDICARE BILLING FORMS

(Reference Committee "F")

Resolution #13 (Hudson County) called upon The Medical Society of New Jersey to go on record as favoring a change in the Medicare form to include the amount due the physician

by the patient, with said amount be clearly indicated as in the original form.

MSNJ has been informed that Prudential has agreed to change the form as called for in the resolution.

Approved (page Tr 140)

MEDICARE PEER REVIEW COMMITTEE (Reference Committee "F")

At its 20 December 1970 meeting, the Board considered a suggestion that the Society make available to the Prudential Insurance Company, as fiscal intermediary for the Medicare Program, the names of physicians in areas of practice designated by Prudential to serve as members of a Medicare Peer Review Committee, to meet, at the call of the Company, to review and evaluate claims involving questions of over-utilization under Medicare. The physicians on this peer review committee will be compensated for their services by Prudential.

The Board agreed to approve the proposal on the following terms:

Nature and Function . . . The Medicare Peer Review Committee—to be established and operated by the Prudential Insurance Company as fiscal intermediary for the Medicare Program—will be composed of 5 groups of 3 members each in the fields of General Practice, General Surgery, Internal Medicine, Ophthalmology, and Urology. The Committee personnel will be nominated to Prudential by The Medical Society of New Jersey. It will be the function of the Committee to review situations centering about physicians who require repetitive scrutiny of their claims because they seem to involve over-utilization.

1. Committee panels will meet at the call of the Company, as need indicates.
2. Committee members will be compensated by The Prudential at a rate subsequently to be agreed upon.
3. A medical representative of The Prudential—either Dr. James F. Brennan or Dr. Carl N. Ware—will attend each Committee meeting, in an advisory capacity.

4. Meetings will be held at convenient geographical locations in North, Central, and South Jersey.

Operational Procedure . . . After a review of the materials furnished by Prudential, the Committee will make an evaluation and proceed as follows:

1. Report that it finds no question of the validity of the claims.
2. If such question is found, invite the physician under review to appear before it.
3. A medical representative of The Prudential—either the Committee, Prudential will follow-up to make certain that the Committee's recommendations to the physician have been implemented.
4. If a reviewed physician in the opinion of the Committee has acted in violation of the Principles of Medical Ethics and/or the Standards of Professional Conduct, the Committee shall then file formal charges alleging such violations with the Judicial Mechanism of The Medical Society of New Jersey.
5. Any reviewed physician who is dissatisfied with the determination made by the Committee shall be entitled to request a hearing before the Joint Medicare Claims Inquiry Committee.

Approved. The Reference Committee urged that the peer review concept be oriented to function with the State committee following initial scrutiny at the county medical society level. (page Tr 140)

PAYMENT FOR PHYSICIANS' SERVICES IN OUT- PATIENT DEPARTMENT FOR RECIPIENTS OF TITLE XIX (Reference Committee "F")

Resolution #22 (Camden County) as adopted by the House of Delegates directed the Board of Trustees to seek modification of a New Jersey Medicaid regulation that prohibits the physician serving in a clinic from filing a claim for the professional component of the out-patient fee, or to urge hospitals to contract for these services as authorized by law.

The Federal Government's *Handbook of Public Assistance Administration*, Supplement D, states the general aims of the Medicaid Program.

"The Congress has made very clear its intent that the medical and remedial care and services made available to Title XIX recipients be of high quality and nowise inferior to that enjoyed by the rest of

the population. To make sure that the concept of quality is not lost sight of the law requires states to establish methods and standards to assure high quality care." D-5144

In view of the above language, the regulation promulgated by the New Jersey Medicaid Administration in regard to out-patient service in a clinic setting appears to be well founded as a stimulus for quality care and encouraging the physician and patient to utilize private office facilities rather than clinic facilities.

Likewise the *Handbook on Public Assistance Administration* also declares "... a token service which can only be ineffective on the one hand and wasteful of funds on the other will not be considered satisfactory." D-1540

Since the physician's time in the clinic is limited and the atmosphere not parallel to his private office, and since the professional component of his bill added to the hospital component would presumptively exceed his charge for an office visit, a change in the regulation would be in opposition to federal policy.

Whether or not a physician should contract with a hospital for his services is a matter between the physician and the respective hospital. It is purely local in nature and a matter of individual choice. Determination of hospital policy is the concern of the medical staff of the institution in question.

Approved. The Reference Committee recorded itself as feeling "that guidelines could be formulated at the State level that would be helpful to hospitals and physicians in determining an individual choice." (page Tr 140)

PHYSICIANS' EXCLUSIVE RIGHT TO RENDER MEDICAL JUDGMENTS (Reference Committee "F")

This resolution (Monmouth County) called upon The Medical Society of New Jersey to "utilize its full resources to ensure that medical decisions remain the domain of the physician only, and that no such decisions may be

effected by lay people; and further to ensure that all policy decisions, federal, state and local, be reached only with full consultation with qualified treating physicians."

The Board referred this resolution to the Council on Legislation and the Council on Medical Services for its implementation.

Approved (page Tr 140)

HAZARDS OF AIR POLLUTION (Reference Committee "G")

The 1970 House of Delegates (Resolution #14—Essex County) called upon MSNJ to instruct its delegates to the AMA to endorse a resolution urging the AMA to initiate a continuing campaign to publicize the perils of air pollution and to expand research and effective control measures. A resolution (#83) was introduced and supported by New Jersey's Delegation at the AMA Annual Convention.

Kentucky introduced a similar resolution (#40) calling on the AMA to intensify and expand its present efforts in the control of environmental pollution. The Reference Committee (E) combined both resolutions in a substitute which the House adopted. The substitute resolution mandates continued and intensified efforts on the part of the AMA to alert the public to the hazards of environmental pollution and to step up pollution control.

Approved (page Tr 143)

FAA MEDICAL EXAMINATION FORM (Reference Committee "H")

The 1970 House of Delegates approved that section of the report of the Board of Trustees dealing with "FAA Medical Examination Form." In granting that approval the House also approved the recommendation of Reference Committee "H" that the AMA be encouraged to continue to work on this problem.

Under date of 2 July 1970, the Society was informed by the Secretary of the AMA's Com-

mittee on Aerospace Medicine that the FAA has not seen fit to adopt the AMA proposal to require a release form for the pilot's personal physician on the FAA examination blank. The AMA Committee still stands on its original statement as to what should be done, even though the FAA has not seen fit to adopt the AMA's recommended procedure. There has been no further action by the AMA Committee since 1967, although the Committee has discussed the matter several times and agreed that the original statement of 1967 is still its policy.

Approved. The Reference Committee urged "that continued action be taken to pursue the position of the AMA regarding the FAA Medical Examination Form." (page Tr 145)

Supplemental Report #1

As the result of its 18 April meeting, the Board of Trustees directed several items to the attention of the 1971 House of Delegates. The Board therefore submits this Supplemental Report #1, which has been compiled since the preparation of its annual report.

FLUORIDATION OF PUBLIC WATER SUPPLIES (Reference Committee "A")

In view of the fact that Senate Joint Resolution #23 seems well on the way to passage, the Committee on Child Health felt it would be desirable to review the Society's position in relation to public water supplies.

SJR-23 creates a nine-member bipartisan commission (two Senators, two Assemblymen, four citizens appointed by the Governor, and the Commissioner of Health) to study the merits of fluoridation of public potable water supplies as a public health measure. This Joint Resolution was brought about by the fact that there is before the Legislature Senate Bill #636, which would prohibit the Public Health Council of the State Department of Health from promulgating any regulation in the State Sanitary Code requiring protec-

tion against dental decay by mandatory fluoridation of any public potable water supply in the state. The Commission would hold hearings to evoke all points of view regarding the fluoridation of public water supplies.

The Medical Society of New Jersey, in a resolution adopted by the House of Delegates in 1952, and reaffirmed in 1960, has recorded itself as approving the fluoridation of public water supplies in this state under regulations promulgated by the State Department of Health. However, the Society has adopted an official position of approval regarding S-636, which would prohibit mandatory fluoridation.

The Committee on Child Health pointed out that in the areas of the state where the water supply is provided to many communities by a single company, it is a practical impossibility to achieve fluoridation of such water supply by means of local referenda in the individual communities. In consequence, indications are that the only practicable means of effectuating the fluoridation of the state water supplies will be a mandatory program under the aegis of the Department of *Environmental Protection*.

The Committee gave as its opinion that the Society's position as expressed in its policy declaration and as reflected in its approval of Senate Bill #636 is contradictory. The Committee therefore recommended, and the Board approved, that the official position on S-636 be changed from approval to disapproval. The effect of the change is to record the Society as approving the mandatory fluoridation of public water supplies. The Board also adopted a second recommendation from the Committee indicating that the Society support such mandatory fluoridation on a state-wide basis under regulations to be promulgated by the proper State agency or department as the only feasible method to accomplish fluoridation of public water supplies in New Jersey.

Approved as amended by the Reference Committee. (page Tr 130)

DESCRIPTION OF MSNJ'S EMPLOYEES' PENSION
PLAN
(Reference Committee "B")

The Board received the following description of MSNJ's Employees' Pension Plan, as prepared by the Business Manager, and directed that it be supplied for the information of the House.

Name of Plan: The Medical Society of New Jersey Employees' Pension Plan

Company: The Medical Society of New Jersey

Effective Date: June 1, 1955 (Plan)
June 1, 1970 (Amendment No. 1)

Method of Disbursing Benefits: Trustee shall disburse benefits from the Fund upon Committee authorization.

Date of Execution: 15 March 1970

Date of Formal Announcement: 5 March 1970

Date when Description of Plan made Generally Available to Employees: 5 March 1970

Date when Plan and Trust Were Put into Effect So That Contributions were Irrevocable: 7 August 1970—Approval Internal Revenue Service.

Summary of Provisions:

(i) *Eligibility Requirements:*

(a) Regular, full-time employment (20 hours per week and 5 months per year).

(b) Completion of at least three years of continuous employment.

(c) Attainment of twenty-fifth birthday, but entry required before age 49½.

(ii) *Employee Contributions:* None

(iii) *Employer Contributions:* The Society shall pay to the Trustees from time to time

the amounts which are needed to provide the benefits specified in the plan.

(iv) *Formula for Determining Amount of Each Type of Benefit:*

At Normal or Late Retirement Date: For a Participant whose participation ended prior to June 1, 1970 and/or whose Normal Retirement Date is earlier than June 1, 1970, a monthly pension for at least 120 months and for life thereafter, equal to the sum of (a), and (b):

(a) 1% of the first \$300 of the Participant's basic monthly compensation on his entry date, plus 2% of any excess over \$300, the sum multiplied by the number of completed years of his participation in the Plan.

(b) any applicable adjustments amounting to \$10.00 per month or more, positive or negative, arising from changes in compensation occurring subsequent to entry into the Plan but prior to the fifth Plan Anniversary (June 1) preceding Normal Retirement Date.

(Special rules apply to a Participant who enters the Plan at age 45½ or older).

For any other Participant, a monthly pension for at least 120 months and for life thereafter equal to the sum of (a) and (b):

(a) the product obtained by multiplying his Credited Service by 1.4% of his Average Compensation.

(b) the product obtained by multiplying his Credited Service by 0.6% of his Excess Average Compensation (in excess of \$500).

•Notwithstanding anything to the contrary herein set forth, every Participant who retires on or after his Normal Retirement Date with at least fifteen (15) years of Credited Service shall be entitled to a Minimum Monthly

•Proposed to be effective 1 June 1971

Normal Pension determined as 50% of his Average Compensation, less 50% of his Primary Social Security Benefit payable on his Normal Retirement Date.

"Average Compensation" means the highest average monthly compensation determinable for a period of five consecutive Plan Years within the ten-year period immediately preceding Normal Retirement Date.

For any Participant, a minimum monthly normal pension of \$10.00 is provided.

Normal Retirement Date is the June 1st nearest 65th birthday. Late Retirement may be granted, with the special consent of the Society; the accumulation of Credited Service will cease at Normal Retirement Date, but the amount of pension will be actuarially increased.

At Early Retirement Date: A member who has completed at least 10 years of service and attained his 55th birthday may, with the consent of the Society, elect an early retirement date, or he may be retired by the Society. Pension is determined as above, except that the amount so determined will be actuarially reduced for the number of months by which his first pension payment precedes his Normal Retirement Date.

Disability Benefits: A member who qualifies for Social Security disability benefits will be entitled to a disability pension under the Plan, computed in the same manner as an Early Retirement Pension. This disability pension will cease in the event of recovery prior to Normal Retirement Date.

Death Benefits:

Before Retirement: None under the Plan, except that any Participant who enjoyed death benefit coverage prior to the Amendment shall continue to be covered in that same amount.

After Retirement: Same as above, except that if death occurs before 120 monthly pension

payments have been received, the balance of 120 monthly payments will be continued to a designated beneficiary.

Options:

Duration: Joint and Survivor Options are available, and, in addition, special options, subject to Committee approval; Social Security Option available at early retirement.

Termination of Employment and Vesting: Full vesting after completion of ten years of participation, with partial vesting, at the rate of 10% for each completed year of participation, prior thereto.

Method of Funding: The Fund will be held by the Trustee as provided under the terms of the amended Trust Agreement.

(vi) *Discontinuance of Plan:* In the event of discontinuance of the Plan, the assets remaining in the Fund shall be allocated in the following order:

- (a) To provide continuing payment of pensions to each retired Participant (or beneficiary) then receiving payments from the Fund.
- (b) To provide pensions to active Participants who are then eligible for retirement, determined as though they retired just prior to the date of discontinuance.
- (c) To provide pensions for all other active Participants, determined as though they became eligible for Early Retirement just prior to the date of discontinuance.

The available assets will be fully allocated to all members of one class before any assets are allocated to the next class. However, the limitations of Regulations 1.401-4 (c) will apply.

Approved (page Tr 133)

SPECIAL COMMITTEE ON TRAFFIC SAFETY
(Reference Committee "D")

The Board considered a request from the Chairman of MSNJ's Special Committee on Traffic Safety recommending that the Committee be discontinued.

The Board approved the request, with indication that any items that would have hitherto been assigned to the Special Committee on Traffic Safety in the future will be referred to other appropriate councils or committees such as Public Health, Legislation, and Medical Services, and Emergency Medical Care.

Approved (page Tr 136)

SPECIAL COMMITTEE ON POLITICS AND
MEDICINE
(Reference Committee "E")

The Board received, and accepted with thanks, the report of the Special Committee on Politics and Medicine. The report contained the following significant summary comments:

The Committee points out that in contemporary America because of the intimate participation of politics and government at all levels in all aspects of health care, the physician can no longer realistically remain aloof from politics. The physician should therefore become increasingly knowledgeable in regard to the impact of political activity on health care, the practice of medicine, and the physician as an individual in society. To do anything less would be to disregard his obligation to protect the interests of the public and of the profession.

It is clear from standing legal opinions that:

1. The Medical Society of New Jersey is free to, and should, educate physicians in the need for a realistic view of politics and of measures affecting medical care delivery.
2. The Medical Society of New Jersey is free to, and should, take a stand on matters affecting quality and delivery of medical care and in protection of the interests of the citizens of New Jersey in this field.
3. Any financial or political support of a given candidate by The Medical Society of New Jersey is untenable under our existing charter and current IRS rulings.
4. A physician as a citizen is free to, and should, take a stand concerning candidates or issues affecting him as an individual, or the general good as he sees it.

The Committee believes that The Medical Society of

New Jersey's *Membership Newsletter* and its bulletins evaluating state and national issues and pending legislation, reflecting the official stand of The Medical Society of New Jersey, are effective instrumentalities of service and should continue.

The Committee feels that The Medical Society of New Jersey should continue its role as a positive factor in initiating constructive legislation affecting medical care.

The Committee commended the Council on Legislation for its vitally important work and accomplishments.

In conclusion the Committee offered, and the Board adopted, the following recommendations:

1. That the Council on Legislation continue intensively to study and, as indicated, revise the legislative contact system for increasing effectiveness.
2. That the aims of JEMPAC be endorsed.
3. That members of The Medical Society of New Jersey be encouraged to join JEMPAC.
4. That The Medical Society of New Jersey have no official ties with JEMPAC.
5. That JEMPAC be more responsive to the wishes of individual members in its process of selecting candidates and issues, and that it aggressively stimulate interest on the part of component societies by appearing before them or by using other means of increasing membership in and support of JEMPAC.

Since the Committee has completed its assigned task, the Board directed that it be discharged with thanks.

Approved (page Tr 137)

SEPARATE DEPARTMENT OF MENTAL HEALTH
(Reference Committee "F")

The Board of Trustees considered and voted to approve the following recommendation from the Council on Mental Health:

That MSNJ reaffirm its position favoring the establishment within the State Government of a separate Department of Mental Health, with a Board-certified psychiatrist in charge and responsible directly to the Governor.

Approved (page Tr 140)

Judicial Council

John S. Madara, M.D., Chairman, Salem

(Reference Committee "A")

PREFATORY STATEMENT

The House of Delegates is the legislative body, the Board of Trustees and the officers constitute the executive body, and the Judicial Council is the judicial body of The Medical Society of New Jersey. The Judicial Council has plenary responsibility for the supervision and maintenance of the judicial mechanism.

The Judicial Mechanism is a form of peer review. It operates under the Society's Bylaws and under a set of "Rules and Regulations For The Processing of Grievances and Complaints," which have been formulated and promulgated by the Judicial Council under the authority vested in it by the Bylaws.

All inquiries, complaints, or accusations, from any source, concerning the "ethical deportment" or "professional conduct" of members of MSNJ are proper to the jurisdiction of the judicial mechanism.

The Council has clarified these terms in its official declaration setting forth the "Fundamentals" underlying the processing of grievances and complaints, as follows:

The "ethical deportment" of a member-physician is to be judged in terms of his adherence to, and conformity with, the official "*Principles of Medical Ethics of the American Medical Association*, and the interpretations thereof made by the AMA Judicial Council and the Judicial Council of The Medical Society of New Jersey."

The propriety of a member-physician's "professional conduct" is measurable in terms of two basic considerations:

(a) his conformity to the standards of enlightened human conduct proper to, and expected of, a gentleman and a member of a learned profession; and

(b) his consistent rendering of professional services of such character as demonstrates that he exercise ability and competences and utilize techniques and procedures consistent with a method of healing founded on a scientific basis.

The success of the judicial mechanism as one of the peer review modalities being used to preserve the good name of Medicine and its practitioners in New Jersey, and to insure uniform standards of professional performance and service, depends upon two things—the full cooperation of the judicial committees of our component societies and the understanding and cooperation of all our members.

The judicial mechanism is confidential in its operation. It is not intended either to coerce or to exculpate member-physicians. It is intended to demonstrate that within the family, as it were, Medicine can equitably and amicably settle its own problems in the areas of ethical and professional conduct.

The Judicial Council of The Medical Society of New Jersey and the judicial committees of the component societies are definitely not merely advisory in character. They hold power, under the Constitution and Bylaws of MSNJ, to receive and adjudicate complaints from any source concerning the professional conduct or ethical deportment of members of MSNJ.

The decisions of the judicial committee of a component society are binding upon all members of that component society, and the judicial committee of each component society in the enforcement of its findings, duly arrived at, has the power "to censure, suspend, or expel any member of its society for just cause." All decisions of the Judicial Council and of the judicial committees are binding upon the respective members of MSNJ. They are not offered to members merely as advice.

No member is free to decide whether or not he will conform to them. Any principal to a complaint, dissatisfied with the findings of the judicial committee regarding the complaint, may appeal to the Judicial Council.

The Judicial Council has maintained its schedule of regular monthly meetings. From its official records and reports the Council here presents a summary of its operations and those of county judicial committees for the period from 1 April 1970 through 31 March 1971:

BY JUDICIAL COMMITTEES

Complaints reported as disposed76

Alleging:	
Dissatisfaction concerning fees	33
Unethical conduct	22
Dissatisfaction with services rendered	11
Unprofessional conduct	10

BY THE JUDICIAL COUNCIL

Meetings held	7
Official communications acted upon	38
Appeal hearings requested	9
Appeal hearings granted	3
Formal opinions rendered	3

- (1) The ethicality of physicians' charging interest on the balance of unpaid medical bills.
- (2) The acceptability of a physician's inscribing the following statement on medical bills submitted to patients: "Bill is payable on presentation. Insurance Forms executed only when account is paid in full."
- (3) The ethical acceptability of certain billing procedures for professional associations.

The foregoing opinions are presented in full as an appendix to this report.

ADHERENCE TO REGULATIONS

The Council points out to the chairmen of the judicial committees of the component societies that there continues to be some inadequacy of cooperation with the Judicial Council on the part of the committees. One of the main problems is failure to file, or lateness in filing, the required report forms to inform the Council of the existence and status of

complaints before county judicial committees. Many times the Council has received requests for appeal hearings concerning complaints disposed of, but not reported, by county judicial committees.

In other instances, investigation has disclosed that some county judicial committees disregard the requirement that all principals be invited to be present and to participate in the hearings that are mandated whenever an amicable settlement proves impossible of accomplishment. The Council urges that each county committee strive to improve its procedures in these regards. Therefore, the committees are again reminded to follow the directions contained and the procedural steps outlined in the *Rules and Regulations for the Processing of Grievances and Complaints*. Only by means of a full understanding and observance of the "Regulations" can the judicial committees together with the Judicial Council succeed in functioning at the level of adequacy intended by MSNJ's House of Delegates.

ON THE AVOIDANCE OF GRIEVANCES AND COMPLAINTS ALLEGING INFRACTIONS OF THE PRINCIPLES OF ETHICS OR THE STANDARDS OF PROFESSIONAL CONDUCT

On the basis of its experience through the years with a wide diversity of complaints addressed to the judicial mechanism, the Judicial Council offers the following basic observation: "Most complaints are generated by dissatisfaction on the part of the patients with what they regard as lack of interest, consideration, and courtesy on the part of individual physicians and/or their employees."

As a constructive means of encouraging our members to do justice to themselves and the profession through the establishment and maintenance of rapport with patients, some years ago the Council on Public Relations offered a series of recommendations which the Judicial Council is pleased to re-emphasize for all members of MSNJ at this time, for the purpose of improving not only the image but the substance of medicine in

the eyes—and hearts—of the people of New Jersey whom we serve. These are the recommendations:

DO . . . remember always that nothing but your best—in service and in courtesy—is permissible or acceptable.

DO . . . be considerate of each patient's point of view and of each patient's problems; he looks to you to be a friend in need.

DO . . . be tolerant toward others, including your colleagues, but exacting toward yourself.

DO . . . take the time to explain procedures and to discuss costs with your patients.

DO . . . expect proper compensation for your professional services but be disposed generously to give *yourself* away.

DO . . . be at pains never to be so busy as to lack time to do the considerate little things that prove how big you really are.

DON'T . . . be late for appointments; regard your patient's time as of equal value with your own.

DON'T . . . leave your practice uncovered; arrange with a dependable colleague to take care of calls received in your absence.

DON'T . . . be easily annoyed. If you are, it means that your head is bigger than your heart.

DON'T . . . be afraid to be friendly. Only the consciously inadequate erect protective barriers of aloofness.

DON'T . . . be indecisive or vacillating. Your patient's confidence in you will be in direct proportion to your decisiveness and definiteness.

Opinion #1

THE ETHICALITY OF PHYSICIANS' CHARGING INTEREST ON THE BALANCE OF UNPAID MEDICAL BILLS

The Council's attention was directed to a request for an opinion from the Chairman of the Judicial Committee of a component society as to whether it is ethical for a physician to charge interest on the balance of unpaid medical bills.

It was the Council's unanimous opinion that the imposition of extra charges, either as interest on the basic indebtedness or as a penalty for late or delayed payment, has been declared by the Judicial Council of the American Medical Association as incompatible with

the dignity of the profession of Medicine. The practice, therefore, is, in view of the Judicial Council of The Medical Society of New Jersey, not acceptable according to approved standards of professional conduct.

Opinion #2

THE ACCEPTABILITY OF A PHYSICIAN'S INSCRIBING THE FOLLOWING STATEMENT ON MEDICAL BILLS SUBMITTED TO PATIENTS: "BILL IS PAYABLE ON PRESENTATION. INSURANCE FORMS EXECUTED ONLY WHEN ACCOUNT IS PAID IN FULL."

This request for an opinion from the Executive Director of a component society in the name of the Chairman of the Judicial Committee was directed to the Council's attention. In considering the question as to whether it was ethical to inscribe on bills submitted to patients: "Bill is payable on presentation. Insurance Forms executed only when account is paid in full," the Council rendered the following opinion:

The report of the Judicial Council of the American Medical Association, adopted by the AMA House of Delegates at the Clinical Convention in Boston in 1970, contained the following relevant paragraphs:

Some physicians seem to believe that the practices of business enterprises should be utilized by physicians in order to "Encourage prompt attention to Medical Accounts." They ask, "why shouldn't we be paid as soon as the dry goods store, the grocer, or the T.V. serviceman?"

Ideally, the physician should be paid promptly. If the physician is not paid as promptly as other creditors he should recall that he is a professional man, with all the prerequisites that the term implies. Our patients in large number carry insurance to cover the cost of medical services. (They do not insure payment of the cost of other professional or business services to any notable extent.) Governmental programs have been instituted and are being developed continually to provide payment for medical care to those who are unable to provide this payment.

The Judicial Council, in the light of the foregoing citation, points out:

1. That peremptory demand for immediate payment of bills rendered to patients by physicians is a practice incompatible with the dignity of medicine as a profession.

2. To insist on payment from a patient before necessary insurance forms will be completed is to disregard the fundamental fact that many, if not most, people who carry, or are covered by, insurance to pay for health care services have acquired or been granted that coverage precisely because their own means would prove inadequate to meet any substantial such costs. To demand cash of them is to ask them to supply what they have not, and is to set at naught the whole protective insurance mechanism made available to assist them to meet their credit obligations to providers of health services.

3. The Judicial Council of the American Medical Association has formally declared:

"The attending physician should complete without charge the appropriate 'simplified' Health Insurance Council forms approved by the Council (AMA) on Medical Service, and similar insurance claim forms as part of the physician's service to the patient to enable him to receive his benefits."

For all the foregoing reasons, the Judicial Council declares that the practice in question is not permissible because it offends the accepted standards of professional conduct.

Opinion #3

THE ETHICAL ACCEPTABILITY OF CERTAIN BILLING PROCEDURES FOR PROFESSIONAL ASSOCIATIONS

Specifically the questions centered about performance of a surgical procedure by two physicians, members of the same professional corporation, in which one physician performs the surgical procedure and the second physician assists him. The following points were made clear:

1. The patient, will, prior to surgery, be informed that an assistant physician is to be used and that physician's name will be supplied.

2. The surgeon will charge his usual fee and his assistant will charge a separate fee.

3. The professional service corporation will submit a bill which will clearly identify the two physicians and the service which each rendered, with a separate fee indicated for each of those services.

After discussion, the Councilors agreed that if all the listed details are followed and the patient is fully informed and consenting—knowing in advance the identity of the assistant and the function that he is to perform, and realizing that a separate fee will be assigned for the assistance rendered—then, under these circumstances, there can be no question of ethical irregularity.

One further question was asked:

"Is there any relevance in this matter if the assistant is or is not a member of the same professional service organization as is the surgeon?"

With reference to this point the Council advised that if the use of the assistant meets the requirements regarding the qualifications for surgical assistants and any other specifications imposed by the hospital in which the surgery is to be performed there seems to be little possibility of any question of ethical unacceptability.

Approved as corrected. The Reference Committee directed the attention of the membership to the portions of the report dealing with "Adherence to Regulations" and "On the Avoidance of Grievances and Complaints Alleging Infractions of the Principles of Ethics or the Standards of Professional Conduct," stressing that strict compliance is necessary to preserve a good public image. (page Tr 130)



Speakers' Platform—1st Session, House of Delegates.

Executive Director

Richard I. Nevin, Trenton

(Reference Committee "A")

Looking back on the record of our Society's involvements and activities over the last decade, it soon becomes evident that succeeding administrative years have been progressively engaged in a depressing game of "Can you top this?". Just when we feel that no year could possibly bring more challenges, greater complexities, or graver crises than that through which we have just passed, the next year proceeds to "out-Herod Herod." Medicine is, of course, perturbed by the problems that confront it in the field of health care services, but—and there may be some melancholy solace in the thought—all other areas of contemporary life, both in our country and everywhere else in the world, are equally bedevilled. These are truly times that try men's souls. We can prove our mettle by the way in which, with no compromise of worthy goals and no diminution of zeal or effort, we stalwartly devote ourselves to doing our best and our utmost to overcome the evils that abound and to make sure that that which is right and good prevails.

That is what we of The Medical Society of New Jersey have been earnestly trying to do. The reports before the House reflect the intense efforts that have been put forth by our officers, and by the members of all our councils and committees, to meet and deal with the challenges of the year. In addition to the matters regularly dealt with through the various agencies of the Society, special attention was given to such significant and pressing subjects as medical manpower and distribution, undergraduate and postgraduate medical education, the development of allied medical personnel, peer review procedures, health maintenance organizations, and the medical foundation concept, to name but a few. As a means of blueprinting effectively for further activities and operations, President Satulsky was empowered by the Board of Trustees to establish a Special Committee on Long

Range Planning and Development. At the time of the compilation of this report that Committee is being constituted and is preparing to organize its program. There can be no doubt that the Society has real need of the service that the Long Range Planning and Development Committee is being called into being to supply. Improvisations are acceptable when circumstances make impossible the employment of well-thought-out and painstakingly evaluated plans, but it is the part of wisdom to keep such circumstances to a minimum.

Under Doctor Satulsky as President the Society has enjoyed a year of truly dynamic leadership. His spirit of dedicated concern for the interests of the Society and his energetic attention to the demands of his office have served as an inspiration and stimulus to all working with him. The members of the Board of Trustees, as usual, have, with admirable consistency, given to the full of their time and of themselves. The same observation applies to the members of the Society's councils and committees.

I pay special tribute to the members of our staff. Each is a person of specialized competence, deeply dedicated to the Society and conscientious in making a contribution frequently above and beyond the basic call of duty. Working with them for the Society has been to me a source of deep personal enrichment and pride.

Mr. Maressa, my Executive Assistant, has taken an increasing part in sharing with me the burdens of my office, especially in the matter of participating in council and committee meetings. Still, in the course of the year, apart from my basic desk duties, I find that I participated personally in about 165 meetings and conferences of all kinds, visited 11 com-

ponent societies, took three trips out of state on official business, and made 12 speech presentations.

Probably no group of people acquit themselves of a greater burden of responsibility, work more *unremittingly*, and suffer more baseless criticism than do the members of the medical profession. Yet constantly demands are made that physicians see more patients, elevate the standards of medical care, reduce costs, man peer review mechanisms, engage more actively in continuing education, partic-

ipate in community planning and programs, and interest themselves increasingly in politics. The situation would be flattering if it were not so genuinely frightening. However, the fundamental and antidotal fact is that the tasks of physicians have always been such as can be performed only by men and women of greater than average aspiration, ability, and dedication. In that pattern, the profession of Medicine has developed and flourished. In that pattern it will triumphantly survive.

Approved as corrected (page Tr 131)

Annual Meeting

James A. Rogers, M.D., Chairman, Paterson

(Reference Committee "H")

The committee met in July to formulate plans for the 205th Annual Meeting in accordance with directives of the 1970 House of Delegates and of the Board of Trustees. Two joint meetings with the committee, officers of the Scientific Sections, and representatives of New Jersey Specialty Societies were held—one in September and one in November.

The final meeting of the 1970-71 Board of Trustees will be held in Haddon Hall at 4:00 p.m., Friday afternoon, 14 May; and the reorganization meeting will be held at 8:30 a.m., on Wednesday, 19 May.

The 1971 House of Delegates will meet on Saturday (15 May), Sunday (16 May), and Tuesday (18 May). Official guests will be called upon to make brief presentations at the first session only. Also during the first session, the Deans of New Jersey's two medical schools will be called upon to receive their AMA-ERF checks. A General Session on "A Review and Report on Recent Developments

and the Current Status of the College of Medicine and Dentistry of New Jersey" will follow the first session of the House. An Open Discussion on Medical-Surgical Plan of New Jersey is also scheduled for Saturday afternoon.

The second (election) session of the House will be followed by the farewell address of the outgoing President and the inauguration of the incoming President. The third session of the 1971 House will open promptly at 9:00 a.m. on Tuesday and will be limited exclusively to the business of the House.

The Nominating Committee will meet at 4:30 p.m. on Saturday; and reference committees are scheduled for 11:00 a.m. on Sunday. Reference committee reports will be made available in advance of distribution to the House to members of the reference committees and to one officially designated representative of each component society.

Registration will open in the Exhibit Hall at 10:00 a.m. on Saturday. The fourteenth Golden Merit Award Ceremony will precede the first session of the House on Saturday and will be followed by a Reception for Award Recipients and their immediate families.

In an effort to avoid conflict with the sessions of the House, the 1971 scientific sessions are scheduled for Sunday morning and early afternoon, and for all day Monday. The 1971 Motion Picture Theater will be sponsored by Roche Laboratories, Division of Hoffmann-LaRoche, Inc., and an outstanding selection of timely films will be shown.

Each year the technical exhibitors are guests of the Society at a reception-buffet dinner. This year the exhibitors will be our guests at a Cabaret featuring entertainment as well as dining and dancing. Everyone registered at the annual meeting will be invited to attend. Tickets will be on sale at the Registration Desk.

The Inaugural Reception is scheduled for Sunday evening. All registered members, official guests, and their wives are invited to attend; admission will be by badge. The Annual Dinner-Dance, honoring the President, will be held on Monday evening.

The Advance Program was mailed early in February to the membership, invited speakers and guests, non-member exhibitors, and to editors of journals of nearby state medical societies. The April issue of *The Journal* carried the detailed day-by-day outline of the annual meeting, including abstracts of the scientific session presentations. The final program will be distributed to all who register at the convention.

The third session of the House of Delegates is the only scheduled event on Tuesday, and traffic through the Exhibit Hall on that day has been virtually non-existent for the past several years. Therefore, the Board approved a recommendation of the Committee that this

year—on a trial basis—exhibits open at 12:00 noon on Saturday and close at 5:00 p.m. on Monday. The exhibit hours will be from 9:00 a.m. to 5:00 p.m. on the intervening day.

Twenty-eight scientific, 12 informational, and 40 technical exhibits will be displayed. The Coffee Lounge will again be sponsored by the Prudential Insurance Company of America. The American Association of Medical Assistants, State of New Jersey, will once again be in charge of the Message Center. The Coffee Lounge, Message Center, and all exhibits will be located in the Exhibit Hall, Lobby floor of Haddon Hall. All members and invited guests are urgently requested to visit the exhibits; admission to the Exhibit Hall will be by badge.

Again this year, in an effort to offset the loss of revenue due to reduction in the number of technical exhibitors, the Board approved a recommendation that, in lieu of presenting exhibits, pharmaceutical houses, book publishers, etc., be invited to contribute to the educational fund of MSNJ. We are grateful to the following for their generous contributions: Geigy Pharmaceuticals, Johnson & Johnson, The S. E. Massengill Company, Pfizer Pharmaceuticals, and The Upjohn Company.

The Board approved several recommendations of the committee as possible means of increasing attendance at the first session of the House of Delegates, as well as increasing the flow of traffic through the exhibits during the annual meeting. The following suggestions were referred to and approved by the Woman's Auxiliary:

1. That the Woman's Auxiliary change its schedule of registration to coincide with that of MSNJ—10:00 a.m., Saturday, 15 May;
2. That the Woman's Auxiliary registration area be located in the Exhibit Hall adjacent to MSNJ's registration, rather than in the hotel lobby. In addition, an information desk will be set up at the former location in the hotel lobby.
3. That the Woman's Auxiliary Art Exhibit be located in the Exhibit Hall adjacent to the Auxiliary registration area.

4. That the Woman's Auxiliary plan more activities for their members on Tuesday in an effort to hold them in Atlantic City until the close of the final session of the House on that day.

The House of Delegates has already approved the following annual meeting dates, which have been confirmed with Haddon Hall:

206th annual meeting—Saturday-Tuesday, 13-16 May 1972

207th annual meeting—Saturday-Tuesday, 12-15 May 1973

208th annual meeting—Saturday-Tuesday, 18-21 May 1974

Recommendation

That the 209th annual meeting of The Medical Society of New Jersey be held in Haddon Hall, Atlantic City, Saturday-Tuesday, 17-20, 1975.

Approved (page Tr 145)—By subsequent action (May 19, 1971) Board of Trustees agreed to following necessary changes in Annual Meeting dates: 1972—May 6-9; 1974—May 11-14; 1975—May 10-13 (see Board of Trustees' Minutes in August 1971 issue of *Journal*).

SCIENTIFIC EXHIBITS

Arthur Bernstein, M.D., Chairman

The subcommittee on Scientific Exhibits met on 27 September 1970 and 24 January 1971.

The committee first reviewed its invitation list, brought it up to date, and agreed that applications for space in the 1971 Scientific Exhibits would be mailed early in November. In addition to the usual list, it was further decided to invite those whose applications came in too late for last year's meeting, and to send notices to editors of journals of neighboring state medical societies, calling attention to our annual meeting and extending an invitation to their members to participate in the Scientific Exhibits.

The application form and the regulations were reviewed and the only change made was that of advancing the date for receipt of applications from January 15, to January 1, 1971. The *Membership News Letter* and *The Journal* of the Society were also to be used for carrying information and application form requests.

An Awards Committee was appointed. This committee will judge all scientific exhibits and then meet for final decision. The following awards will be presented this year:

- (1) First and second place award plaques and a third place gold seal certificate for New Jersey exhibitors
- (2) First and second place award plaques for out-of-state exhibitors
- (3) Special Award Plaque from the Committee on Scientific Exhibits to be presented to a New Jersey Exhibitor
- (4) Three Honorable Mention certificates, each to be presented to the New Jersey and out-of-state exhibitors
- (5) A Certificate of Merit and a \$50.00 check to be presented to a student from each of New Jersey's two medical schools who exhibits.

It was agreed that Scientific Exhibit Awards should not be presented as a matter of formality, but rather that they should be presented only when the Scientific Exhibits Award Committee is of the opinion that the exhibit is of such excellence as to be recognized by an award.

It was again recommended that the award presentations for the most outstanding scientific exhibits be made as the first order of business at the third session of the House of Delegates on Tuesday, 18 May, 1971.

It was found necessary to charge \$150.00 for each informational exhibit to be presented in the 1971 session. The only informational exhibits that will be excused from this charge are those from committees of The Medical Society of New Jersey.

There were over 20 applications for space for scientific exhibits for the 1971 annual meeting. These were divided up into "medical" and "surgical." They were further categorized as "diagnostic," "treatment," and "pediatric." These groupings will be used as much as possible in order to add interest to the exhibits and to give some uniformity to the over-all pattern.

The lack of interest by many of the component societies both in the scientific ex-

hibits and in the annual meeting prompted the committee to decide to recommend that a letter should be sent next year to the president of each of the component societies in an effort to stimulate them to write to their members as well as to hospitals in their counties to prepare exhibits that would be of prime interest to the physicians of New Jersey. It was believed by the committee that this would stimulate more interest in our annual meeting and certainly more interest in our scientific exhibits. The Board of Trustees approved this recommendation at its February meeting.

SCIENTIFIC PROGRAM

James A. Rogers, M.D., Chairman

The Officers of the Scientific Sections met twice with the Committee on Annual Meeting.

Following the 1970 Annual Meeting, the Chairman of the Section on Metabolism suggested that that section be disbanded—at least for the 1971 Annual Meeting—because of a lack of interest by that group. The suggestion was approved and the Section on Metabolism was disbanded and absorbed by the Section on Medicine.

In consequence of the action of the 1969 House of Delegates, including the recommendation of Reference Committee "H", "... that specialty groups throughout the State be encouraged to combine all their separate annual meetings at one time under the aegis of the Scientific Sessions of MSNJ and for each specialty to formulate its program to stimulate maximum attendance by its membership . . .," request was made of each New Jersey specialty society for an official indication as to whether or not it approved the proposal and would be willing to participate.

The Scientific Program Committee takes particular pride in announcing that of the sixteen scientific sessions to be presented in 1971, fourteen will be co-sponsored by specialty groups.

All of MSNJ Scientific Sections will meet in 1971—in accordance with the following schedule:

Sunday morning, 16 May 1971

Session on Chest Diseases—co-sponsored by New Jersey Chapter, American College of Chest Physicians
Session on Obstetrics and Gynecology—co-sponsored by New Jersey Obstetrical and Gynecological Society
Session on Otolaryngology—co-sponsored by New Jersey Academy of Ophthalmology and Otolaryngology

Sunday afternoon, 16 May 1971

Session on Anesthesiology—co-sponsored by New Jersey State Society of Anesthesiologists
Session on Cardiovascular Diseases—co-sponsored by American College of Cardiology
Session on Psychiatry and Neurology—co-sponsored by New Jersey Neuropsychiatric Association and New Jersey Psychoanalytic Society

Monday morning, 17 May 1971

Joint Session on Allergy, Medicine
Joint Session on Clinical Pathology, Dermatology—co-sponsored by New Jersey Dermatologic Society and New Jersey Society of Pathologists
Session on Gastroenterology and Proctology—co-sponsored by New Jersey Proctologic Society
Joint Session on General Practice, Pediatrics—co-sponsored by New Jersey Academy of General Practice and New Jersey Chapter, American Academy of Pediatrics
Session on Orthopedic Surgery—co-sponsored by New Jersey Orthopaedic Society
Joint Session on Radiology, Rheumatism
Session on Surgery—co-sponsored by New Jersey Chapter, American College of Surgeons
Session on Urology—co-sponsored by New Jersey Diabetes Association

Monday afternoon, 17 May 1971

Session on Ophthalmology—co-sponsored by New Jersey Academy of Ophthalmology and Otolaryngology
Session on Plastic and Reconstructive Surgery

In addition to MSNJ's scientific sessions, the College of Medicine and Dentistry of New Jersey at Newark will present a special session on "The Physician Faces Drug Abuse" on Sunday morning, 16 May.

In addition to co-sponsoring the scientific programs, nine special luncheon-meetings have been scheduled:

American College of Cardiology—Dutch-Treat luncheon with speaker
New Jersey Chapter, American College of Chest Diseases—luncheon in conjunction with its Annual Selman Waksman Lecture and speaker
New Jersey Obstetrical and Gynecological Society—luncheon for its Council members; and a dinner in the evening for members of that Society
New Jersey Society of Internal Medicine—luncheon-meeting featuring a speaker on the "Socio-Economic Aspects of Medical Practice"
New Jersey Chapter, American Academy of Pediatrics—luncheon-meeting

The following groups have scheduled luncheons:

New Jersey State Society of Anesthesiologists
New Jersey Allergy Society
New Jersey Orthopaedic Society
New Jersey Rheumatism Association

In addition, the New Jersey Committee on Trauma, American College of Surgeons, has scheduled its Annual Trauma Oration which will be preceded by a luncheon.

A total of 80 eminent members and guest speakers will participate in the 1971 scientific programs.

It is hoped that, with the outstanding programs arranged through the joint endeavors of MSNJ's Scientific Sections and the New Jersey Specialty Societies, attendance at the 1971 sessions will be greatly improved over previous years. Each member of the Society is urged to attend the scientific session of his particular specialty.

Approved. The Reference Committee commended the Committee on Annual Meeting "not only for the current program but for changes in the format and innovations made this year." The Reference Committee recommended that "there be further measures investigated for the streamlining of the annual meeting and that a special appeal be made to the younger members of the Society for their participation in the annual meeting." (page Tr 145)

Credentials

Louis F. Albright, M.D., Chairman, Spring Lake
(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The Committee extends appreciation to the secretaries of component societies, and to those who assist them, for their cooperation in processing membership applications. It would be especially helpful to the Credentials

Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials.

The following statistical breakdown reflects the committee's activities during the period 1 April 1970 to 31 March 1971.

	<u>Associate</u>	<u>Active by Advancement</u>	<u>Active</u>	<u>Total</u>
Received	348	276	69	693
Reviewed and found:				
Satisfactory	306	256	57	619
Unsatisfactory	0	0	3	0
Pending	42	20	12	74
Total	348	276	69	693

Approved (page Tr 131)

Honorary Membership

Ralph M. L. Buchanan, M.D., Chairman, Phillipsburg
(Reference Committee "H")

No nominations were submitted this year to the Committee. Consequently, no meetings were held during this administrative year.

No action necessary.

Finance and Budget

Thomas C. DeCecio, M.D., Chairman, Cliffside Park

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

THE JOURNAL

The anticipated *Journal* deficit has increased, for the second consecutive year. This can be attributed to several factors: (1) reduced volume of advertising supplied by SMJAB, while local advertising income has remained stable; (2) the effects of the new rate structure reflecting 15 per cent increase for full and 10 per cent increase for one-half page advertisements, although effective 1 January 1971, has not achieved full impact on *Journal* income; and (3) the effect of a 7.3 per cent production cost increase as of April 1970. The anticipated increase for 1971 is not known at this time. However, this trend is consistent within the printing industry, and it is felt that the printer has rendered another satisfactory year in printing *The Journal*.

The anticipated deficit for publication of *The Journal*, *Journal* salaries and salary taxes (including those of the editor and assistant editor), *Journal* office expenses and travel, editor's insurance, and other *Journal* expenses will be charged off to the unexpended balance in the 1970-71 budget accounts at the end of this fiscal year. A net surplus will still result in the 1970-71 total budget.

Your Committee has approved, with the concurrence of the Board of Trustees for the third consecutive year, the continuation of the *Journal* Deficit Reserve Account established to offset any future deficit when there may not be sufficient unexpended surplus to absorb a *Journal* deficit.

1972 ASSESSMENT

The computation of cash surplus at the close of the current fiscal year is estimated at \$260,654.71—73.8 per cent above the \$150,000.00 sum which has been indicated as the desired minimal surplus.

In accordance with Chapter X of the Bylaws, the dues year is 1 January to 31 December, and the fiscal year is 1 June to 31 May. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It, therefore, becomes necessary to apportion the 1971 and 1972 per capita assessment to the 1971-72 fiscal year on the basis of 7/12 of the 1971 assessment for the new fiscal year soon to commence (1 June 1971) and 5/12 of the 1972 assessment for the latter part of that fiscal year starting 1 January 1972.

The following is the Computation of Cash Surplus and the Determination of the 1972 Assessment:

Proposed budget for 1971-72	\$426,987.00
7/12 of 1971 assessment applicable to 1971-72 budget	221,054.16
Amount to be raised by 5/12 of 1972 assessment	\$205,932.84
$\$73.82 \times 6,696$ members paid = \$494,298.72	
$\times 5/12$	<u>\$205,957.80</u>
Amount to be raised with surplus over \$150,000.00 applied to budget excess at 5/31/71, estimated	\$110,654.71
Amount needed to reduce the per capita assessment from \$73.82 to \$60.00	38,532.84
Remainder of surplus in excess of \$150,000.00	\$ 72,121.87
Add the required surplus	<u>150,000.00</u>
Estimated adjusted cash surplus at 5/31/71	<u>\$222,121.87</u>

$\$60.00 \times 6,696 \text{ members paid} = \$401,760.00$
 $\times 5/12 \dots\dots\dots \$167,400.00$
 plus the amount raised from surplus $\dots\dots 38,532.84$
 Amount to be raised to meet 5/12 require-
 ment $\dots\dots\dots \underline{\underline{\$205,932.84}}$

For each \$1,000.00 increase in the proposed budget add .358¢ to assessment.

For each \$1,000.000 decrease in the proposed budget, subtract .358¢ from assessment.

1971-72 BUDGET

The proposed budget for 1971-72 totals \$426,987.00. It is the opinion of the Committee that the budget should adequately provide the necessary funds for the efficient operation of the Society' business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

Your Committee reviewed with interest a comparison of state dues' assessments provided through the AMA in October 1970. New Jersey ranks fourth from the lowest. Your Committee has approved, with the concurrence of

the Board of Trustees, that this comparison be made an attachment to this report.

As requested by the House of Delegates, the Committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

Recommendations

- 1) That the budget for 1971-72 be adopted in the total sum of \$426,987.00.

Approved (page Tr 133)

- 2) That the 1972 assessment be adopted at \$60.00 per capita, with no provision for a contribution to AMA-ERF. The dues assessment will cover a budget allocation, for the third consecutive year, to the Academy of Medicine of New Jersey, which eliminates the need for a special assessment therefor.

Approved (page Tr 133)

ACCOUNT	CURRENT 1970-71 BUDGET	FOOT- NOTES	PROPOSED 1971-72 BUDGET
A- 1-Executive Salaries	\$ 66,710.40	(1)	\$ 75,693.00
A- 2-General Staff Salaries	113,277.24	(1)	124,960.76
A- 3-General Exec. Offices Expenses	17,000.00	(2)	18,000.00
A- 4-Executive Travel	3,200.00		3,330.00
A- 5-House Maintenance	19,000.00	(3)	19,600.00
A- 6-Treasurer	6,600.00	(4)	7,600.00
A- 7-Finance & Budget	75.00		75.00
A- 8-Secretary	400.00		400.00
A- 9-Salary Taxes	8,749.36	(5)	10,338.24
A-10-Insurance	10,200.00	(6)	10,600.00
A-11-House Reserve	6,500.00	(7)	8,000.00
A-12-MSNJ Pension Plan	1,400.00		1,500.00
C- 2-Legislation	8,400.00		8,400.00
C- 3-Public Health	2,600.00		2,700.00
C- 4-Public Relations	6,800.00	(8)	7,200.00
C- 5-Medical Services	700.00		700.00
C- 6-Mental Health	1,400.00		1,600.00
D- 1-President-Pres. Officers	15,000.00		15,250.00
D- 2-AMA Delegates	12,650.00	(9)	15,110.00
D- 3-Woman's Auxiliary	4,805.00	(10)	3,660.00
D- 4-Medical Education	35,200.00		35,200.00
D- 5-Conference Groups	500.00		500.00
D- 6-Membership Directory	14,000.00	(11)	15,000.00
D- 7-Emergency Medical Care	300.00		300.00
D- 8-Credentials & Membership	600.00		700.00
D- 9-Archives & History	100.00		100.00
D-10-Project Hope-Vietnam	6,000.00		6,000.00
D-11-Med. Def. & Insurance	500.00		500.00

E- 1-Board of Trustees	6,100.00	(12)	6,700.00
E- 2-Contingent	10,000.00		10,000.00
E- 3-Judicial Council	500.00		500.00
E- 4-Legal	7,300.00		7,300.00
E- 5-Health Facilities Planning Council	5,000.00	(13)	
E- 6-Medical Student Loan Fund	12,000.00	(14)	6,000.00
E- 7-Authorized Reimbursement for Representatives to Meetings	3,500.00		3,500.00
TOTALS	\$407,067.00		\$426,987.00

Approved (page Tr 133)

FOOTNOTES FOR BUDGET

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| <p>(1) - Increase due to increments granted to both executive and general personnel.</p> <p>(2) - Increase due to higher office service expenses.</p> <p>(3) - Increase due to higher expense for utilities.</p> <p>(4) - Increase due to higher cost for bookkeeping and auditing services.</p> <p>(5) - Increase due to higher salary taxes resulting from increased staff salaries.</p> <p>(6) - Increase due to higher premiums in employee group insurance programs.</p> <p>(7) - Increase due to accommodate a six year savings program on an exterior painting program -Executive Offices.</p> <p>(8) - Increase due to higher anticipated expenses chargeable to this account.</p> <p>(9) - Increase due to the Board of Trustees' (21</p> | <p>March 1971) decision to send seven regular and seven alternate delegates to both the AMA Annual Meeting in Atlantic City and the Clinical Meeting in New Orleans.</p> <p>(10) - Decrease due to AMA Annual Women's Auxiliary meeting being held in Atlantic City, New Jersey.</p> <p>(11) - Increase due to higher anticipated printing cost for the next edition of the Membership Directory.</p> <p>(12) - Increase due to higher anticipated expenses charged to this account.</p> <p>(13) - No provision due to the dissolving of Health Facilities Planning Council effective 31 December 1970.</p> <p>(14) - Decrease due to the increase in repayment of past loans granted and interest yield from investments.</p> |
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DUES COMPARISON

	ANNUAL DUES		INCREASE			ANNUAL DUES		INCREASE	
	1970	1965	Amount	Percent		1970	1965	Amount	Percent
Alabama	\$ 75	\$ 50	\$ 25	50.00	New Hampshire	\$ 95	\$ 75	\$ 20	26.67
Alaska	200	75	125	166.67	New Jersey	55	45	10	22.22
Arizona	105	105	—	—	New Mexico	105	90	15	16.67
Arkansas	75	45	30	66.67	New York	70	45	25	55.56
California	90	75	15	20.00	North Carolina	145	60	85	141.67
Colorado	70	70	—	—	North Dakota	125	100	25	25.00
Connecticut	50	45	5	11.11	Ohio	50	35	15	42.86
Delaware	85	80	5	6.25	Oklahoma	75	57	18	31.58
District of Columbia	85	70	15	21.43	Oregon	115	60	55	91.67
Florida	75	50	25	50.00	Pennsylvania	75	75	—	—
Georgia	40	40	—	—	Puerto Rico	73	100	*27	*27.00
Hawaii	140	100	40	40.00	Rhode Island	80	60	20	33.33
Idaho	120	100	20	20.00	South Carolina	75	35	40	114.29
Illinois	105	80	25	31.25	South Dakota	125	100	25	25.00
Indiana	90	55	35	63.64	Tennessee	80	40	40	100.00
Iowa	150	90	60	66.67	Texas	55	45	10	22.22
Kansas	75	50	25	50.00	Vermont	65	65	—	—
Kentucky	80	75	5	6.67	Virginia	90	40	50	125.00
Louisiana	85	50	35	70.00	Washington	97	60	37	61.67
Maine	65	55	10	18.18	West Virginia	80	50	30	60.00
Maryland	85	50	35	70.00	Wisconsin	145	90	55	61.11
Massachusetts	35	35	—	—	Wyoming	75	50	25	50.00
Michigan	125	80	45	56.25	Average Increase				35.78
Minnesota	100	75	25	33.33	American Dental Assn.	\$ 55	\$ 40	\$ 15	\$ 37.5
Mississippi	60	95	*35	*36.85	American Bar Assn.	\$ 40	\$ 30	\$ 10	\$ 33.3
Missouri	65	50	15	30.00	American Institute				
Montana	65	65	—	—	of Certified Public				
Nebraska	70	55	15	27.27	Accountants	\$ 75	\$ 55	\$ 20	\$ 36.4
Nevada	150	120	30	25.00					
*Decrease									

Medical Defense and Insurance

William J. D'Elia, M.D., Chairman, Neptune City

(Reference Committee "C")

ACCIDENT AND HEALTH INSURANCE

The Society's Accident and Health Insurance Program has just completed its forty-first year of service to our members. This comprehensive disability income program affords a total benefit of up to \$2,200 a month during total disability due to injury or sickness. The program consists of two parts: the basic-extended plan, and the long-term plan. The plans differ primarily in the length of time benefits are payable. For an accident disability, the basic plan pays up to five years; the basic-extended plan for lifetime; and the long-term plan up to lifetime. For sickness disability, the basic plan pays up to two years; the basic-extended plan up to seven years; and the long-term plan up to age 65. Both the basic-extended plan and the long-term plan are underwritten by the Nationwide Mutual Insurance Company. All of our Accident and Health policies now have the guaranteed conversion-provision rider. Briefly, this rider provides that, if Nationwide were unilaterally to terminate any of its Accident and Health Insurance programs for members of the Society, the company is committed to issue a guaranteed renewable policy for the same benefits as those provided each insured member under the Society's program.

BASIC-EXTENDED PLAN

The basic disability plan provides as much as \$1,200 monthly benefit with the Nationwide Mutual Insurance Company. Benefits are payable from the first day of accident total disability for as long as five years, and from the eighth day of sickness total disability for as long as two years. The plan also pays, at half the monthly benefit rate, from the first day of accident partial disability for as long as six months. The plan also includes accidental death and dismemberment benefits. By adding the extended plan, accident total disa-

bility benefits may be extended to lifetime and sickness total disability benefits may be extended for an additional five years, or a total of seven years altogether. There are 6,328 basic policies covering our members with some members having two basic policies. Extended coverage is included in 2,214 of these policies. Now that all our basic coverage is through one company, many members are combining two basic policies into one, when they are applying for an increase in their monthly benefit.

We have just arranged for a reduction in premium rates for those members under 30 to make the program even more attractive to them. In addition to the first day accident, eighth day sickness basic program that has been in effect for many years, there will now be available options at lower premium costs with benefits beginning on the thirty-first day of accident or sickness or the sixty-first day of accident or sickness. This natural extension of our program broadens its utility for the members.

New members who apply for the basic-extended plan within their new member periods are issued coverage, within certain limits, without regard to medical history.

LONG TERM PROFESSIONAL INCOME PROTECTION PLAN

This plan, through the Nationwide Mutual Insurance Company, provides up to \$1,000 monthly benefit in addition to the benefits provided under the basic-extended plan. Benefits are payable to lifetime for accident total disability, and to age 65 for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall in place, such as annuities, life insurance settlement op-

tions, and social security. The plan also affords six months of partial disability benefits at half the monthly benefit rate. Benefits may begin from the first day of accident or the eighth day of sickness or first day of hospitalization, whichever comes first; or from the fifteenth day, thirty-first day, sixty-first day or ninety-first day of disability with appropriate reductions in premiums for the longer waiting periods. Currently, 901 members participate in this program which began in 1965.

It is possible for a member to have various disability plans and almost any combination of monthly benefits and plans to fit personal requirements. The ideal goal for most physicians is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax free for federal income tax purposes.

The Committee has just arranged for a reduction in premiums for those under the age of 30 and for the Immediate and Fifteenth day plan in the 30 to 39 age category. It is expected that these improvements in the program will make it more attractive to the younger members of the Society and induce their increased participation. E. & W. Blanksteen Agency, Inc. administers these plans for the benefit of our members.

MAJOR EXPENSE PLAN

The program is participated in by 2,553 members with many including coverage for their wives and children. This major expense plan provides up to \$15,000 of benefits paying 80 per cent of covered expenses in excess of a \$500 deductible. Many members who are past the age of 65 continue to be covered under this program which is especially designed to integrate with the coverage provided by Medicare legislation. New members to the Society may obtain coverage under the Major Expense Plan without regard to medical history provided they apply within their allotted two month new member period. E. & W. Blanksteen Agency, Inc. administers this plan.

HOSPITAL-MONEY PLAN

The Hospital-Money plan provides additional cash benefits when hospitalized for members, their spouses, and covered dependents. It can provide \$20, \$30 or \$40 a day for as many as 365 days for any one disability. At relatively low cost it provides benefits at the monthly rate of \$600, \$900 or \$1,200 while hospitalized. In view of the very large costs that accrue when hospitalized, this program fills a real need for members since its benefits are not based on reimbursement for expenses incurred, but are in the form of a daily indemnity based solely on hospital stay. Presently, 377 members are covered under this program many of whom include their spouses and dependents. This plan is administered by E. & W. Blanksteen Agency, Inc.

LIFE INSURANCE

Our term life insurance program now includes not only the member but also his spouse, dependent children (between the ages 15 and 21, or up to age 26 if a college student), and employees. An important feature of this expansion is that each person will have his own five year renewable and convertible term policy and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members especially those who wish to provide benefit programs for their employees.

The life program provides each insured person a five year renewable and convertible term policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program provides up to \$100,000 of coverage for members and up to \$50,000 of coverage for spouse, dependent children, and employees. All coverage is issued in the form of convenient units of \$10,000 with waiver of premium and double indemnity for accidental death included without premium charge.

Last year \$250,000 in death benefits was paid out under this program bringing the total paid from inception to \$2,045,000. Through the large volume of insurance and strong participation of our members in this program, we are able to have non-cancellable term life insurance at a very low cost.

At the present time our members are covered by \$26,040,000 of insurance currently in force.

SIX POINT HIGH-LIMIT ACCIDENT INSURANCE PROGRAM

Our Six Point High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company provides up to \$200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance, and even a total disability feature, at less than the usual cost of the accidental death benefit alone.

Special spouse coverage is available under this policy at very low cost. Of our members, 775 participate in this program.

PROFESSIONAL CORPORATIONS

E. & W. Blanksteen Agency, Inc., our administrator for the Basic-Extended Long-Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, Life Insurance Plan, and Six-Point High Limit Accident Insurance Plan, advises that all the programs are adaptable for use in professional corporations with necessary assignment forms available upon request.

Recommendation

That the E. and W. Blanksteen agency, Inc., be continued as the official broker for MSNJ's Accident and Health, Major Expense, Hospital-Money, Disability, Life, and High-Limit Accident Programs.

Approved (page Tr 134)

PROFESSIONAL LIABILITY

The Committee has given careful consideration to the professional liability program, its problems and functioning, proposed rate increases, and the Loss Control Program.

During the past year the nationwide concern over the availability of malpractice insurance at reasonable rates increased to an intensity never before experienced. Certainly, the problems in Hawaii, Colorado, Utah, Pennsylvania, and elsewhere are today a matter of common knowledge. The Federal Government is considering several proposals but relief from that source will not be readily forthcoming. The inability of the AMA to produce a concrete program, and a willing carrier, only serves to buttress the opinion of the Committee that MSNJ, for one reason or another, has been rather fortunate. We believe we have a sound and stable program providing optimum coverage and security. Appearing below are the more important occurrences that the Committee has dealt with during the past year.

The Committee and the Board of Trustees are of the opinion that the component societies should require that their associate members, as a requisite of their orientation program, attend one meeting—regular or special—of their component society devoted to the malpractice situation, with all other component society members invited to attend. The component societies have been informed of this suggestion.

Once again the insurability of D.O.'s in the employ or partnership of MSNJ members was discussed. The decision reached was that the D.O. will be eligible for professional liability insurance when employed by a member but not when in partnership with him, since the program, by agreement with the carrier, is available only to members and their employees.

It had been brought to our attention that various Medical Review and Advisory Committees were being subjected to procedural pressures, not in the spirit of the Loss Control

Program, by certain employees of the carriers. This Committee, with the approval of the Board, adopted "Official Procedures" which were then distributed to the appropriate parties. We also held a meeting with representatives of the carrier in which we made it abundantly clear that the Loss Control Program could not and would not be altered without the consent of the Committee.

The specialties of pathology and allergy were, because of their favorable experience, moved from Class 1 of practice to Class 6. The change produces a one-third reduction in premium for these specialties.

During the summer, Employers of Wausau proposed a rate increase for the Umbrella Coverage. The Committee did not believe the proposal was justified. The Employers filed its request with the Commissioner of Insurance. Subsequently, the Department of Insurance disapproved the proposed rate increase. Employers of Wausau then notified Mr. Britton, on 27 July 1970, that on and after 1 August 1970 they would not write or renew the Umbrella Coverage. Mr. Britton immediately secured the services of the Employers Commercial Liability Union of Boston, which began writing policies as of 10 August 1970 at the rates formerly used by Employers Insurance of Wausau without the proposed increase. The new policy is improved and includes protection for aviation, partnership, and professional corporations.

Early in October a meeting was held among the Committee, the carrier, the Britton Agency, and the attorneys utilized in the program. The attorneys were unanimous in their disapproval of a project the Committee had considered whereby professional liability case narratives, with guarded anonymity, would be published in *The Journal*. It was felt that there would be certain unavoidable legal complications. That project was abandoned. The attorneys also suggested three areas in which remedial legislation would be of immediate value. These items have been referred to the Council on Legislation for draft and implementation. The one certain admonition

produced at that meeting was that there appears to be a leak of information concerning events transpiring at various Medical Review and Advisory Committee meetings that must be sealed off. Preventive measures have been taken.

Employers Insurance of Wausau presented some proposed amendments to the Loss Control Program to Mr. Britton. As previously noted, the Committee found these suggestions unacceptable. A meeting was arranged and certain modifications agreeable to both sides were approved and transmitted to the Medical Review and Advisory Committees of the component societies.

PROPOSED RATE ADJUSTMENT

In late December 1970 the Committee received notification from the Employers Insurance of Wausau that a 48.5 percent rate increase was indicated. The Committee expressed its dissatisfaction with the projected increase. Wausau was notified that based on the information before it the Committee was not in a position to recommend that the Society either approve or disapprove the proposed increase at the present time. The carrier was also informed that the Committee would not render a final decision as to whether the increase would be acceptable until the Commissioner of Insurance had dealt with it.

At this writing, the Committee has no indication of the determination made by the Commissioner of Insurance nor what the reaction of the carrier will be. We are, however, prepared to meet such exigencies as may arise and will act in the best interests of the membership of MSNJ. It is hoped that final action in this regard will be presented to you through a Supplemental Report.

Recommendation

The the Joseph A. Britton Agency be continued as MSNJ's Official Broker for its Professional Liability Coverage.

Approved with notations (page Tr 134)

Medical Education

James A. Rogers, M.D., Chairman, Paterson

(Reference Committee "D")

PHYSICIANS' ASSOCIATES

The Board of Trustees referred to the Committee for study and report, two documents entitled "Proposed Department of Community Medicine at the College of Medicine and Dentistry of New Jersey at Rutgers" and "Baccalaureate Program for Physicians' Associates at Livingston College, Rutgers University," submitted by Dr. Cross of the College of Medicine and Dentistry of New Jersey at Rutgers. At the recommendation of the Committee, the Board of Trustees approved these programs in principle and directed a letter to the State Board of Medical Examiners inquiring as to what steps are necessary to assure that "Physicians' Associates" may function legally in New Jersey.

COLLEGE OF MEDICINE AND DENTISTRY (NJ)

Late in January the Committee was informed that the State government was considering a drastic revision of the Newark facilities of the College of Medicine and Dentistry of New Jersey that would have in effect converted the Marland Medical Center into an Extended Care Facility, constructed a 500 bed hospital in Newark, deferred construction of the planned medical science facility, required students to take their pre-clinical training at Rutgers, and reverted 40 of the 62 acres held by the College in Newark to the City of Newark for use in the construction of public housing. The Committee recommended that the Society strongly oppose such action and publicly announce the following:

The Medical Society of New Jersey has been distressed by recent developments in the City of Newark that threaten to disrupt the program that is essential for the production in New Jersey of sufficient physicians to deliver adequate medical care to the people of the State.

The House of Delegates of The Medical Society of New Jersey, in May 1970, voting to support the Governor's proposal to establish one corporate body fully to develop and direct the College of Medicine and Dentistry by operating schools of medicine at both Rutgers and Newark, presented to the Governor and the Legislature the following recommendations:

1. That the existing full medical program and facilities at Newark be maintained and expanded as planned.
2. That the present College of Medicine facility at Rutgers be maintained and enlarged to accommodate 100 students per class under a *complete* M.D. degree program, as soon as possible.
3. That a third full degree program school in Southern New Jersey be brought into being as soon as feasible.

Since experience unequivocally demonstrates that most physicians enter into practice in the localities in which they serve their internship and residencies, and, since they seek such internships and residencies almost exclusively in hospitals and medical centers identified and affiliated with medical schools, there can be no hope of increasing the supply of physicians in New Jersey unless the present plans for the full development of both of the present medical schools in New Jersey are adequately financed and carried forward—without delay.

The Medical Society of New Jersey reaffirms the foregoing recommendations and strongly urges their implementation.

The Board concurred and on 3 February 1970 Dr. Satulsky ably presented these views in the name of MSNJ to the Board of Trustees of the College of Medicine and Dentistry of New Jersey. We have been subsequently notified that the objectionable proposals have been altered.

ACADEMY OF MEDICINE

The Board of Trustees referred a request from the President of the Academy of Medicine of New Jersey for approval to circulate a questionnaire among the membership of MSNJ on the subject matter and location of education programs offered through the Academy. The Committee directed a letter to the President of the Academy stating that it did not feel the questionnaire would serve a useful purpose or that it would elicit the information desired.

AMA RECOGNITION AWARD

Last year the Board of Trustees approved our recommendation that the Society strongly urge every member to participate in the AMA Recognition Award Program. The Committee wishes to reiterate and reaffirm that previous action and requests permission to distribute that information to Hospital Administrators, Chiefs of Staff, and Directors of Medical Education.

NEW JERSEY INTERNSHIP PROGRAMS

In the report of the Council on Legislation you will note two bills of concern to this Committee; they are S-2083 and A-2131. These bills, if enacted, would have a deleterious effect on the accreditation of our internship programs and the quality of care rendered in this State. We wish to record our strong disapproval. While the need for more interns and physicians in New Jersey is a patent reality, we do not believe that the quality of current standards should be lowered but that additional educational facilities and programs be made available.

NATIONAL INTERN AND RESIDENT MATCHING PROGRAM

A 4 March 1971 Memorandum from the National Intern and Resident Matching Program was brought to our attention. The National Intern and Resident Matching Program proposes to adopt as its policy, effective

December 1971, that any and all hospitals or educational institutions participating in the National Intern and Resident Matching Program must do so as a corporate entity with the understanding that all approved programs to which graduating medical students are eligible will be included in the program. Non-participation in the National Intern and Resident Matching Program implies that positions in that program are not available to graduating students. The fact that some of the specialty boards have phased out the internship as such and incorporated it into the first year of residency training is significant. Until such time as all hospitals are prepared and willing to meet such conditions, we do not believe they should be mandated to do so. We, therefore, recommended to the Board that MSNJ take opposition to such proposals until they are universally accepted and all participating institutions have been granted an opportunity to be heard.

PEER REVIEW

This topic has generated considerable interest in the past year and obviously will continue to do so in the future. We hope to channel our activities in this regard primarily toward utilization of services and quality of care.

FOURTH YEAR MEDICAL STUDENTS

Currently several medical schools are beginning to require affiliated hospitals to provide training programs for fourth year students. It is anticipated that Federal assistance will eventually be available to these hospitals. Currently, the State of Indiana has initiated a program to reimburse hospitals on a capitation basis for individuals serving in training programs. This may be the means of providing more interest and of injecting better quality into graduate and postgraduate educational programs and will be a subject for our concern next year.

Approved. (page Tr 136)

Medical Student Loan Fund

Frank J. Hughes, M.D., Chairman, Camden

(Reference Committee "B")

In its fourteen years of operation the Medical Student Loan Fund has granted loans totaling \$276,744.35 including \$444.35 as insurance payments, bringing the net loans granted to \$276,300.00.

To date the Fund has issued 262 loans to 158 New Jersey medical students. Sixty-one loans have been repaid in full. Eighteen borrowers are presently making quarterly repayments on an annual basis, and two borrowers are presently making interest payments.

Requests for financial assistance by New Jersey medical students has notably increased during the 1970-71 administrative year. It is expected that this trend will continue for some time. Out of a total of twenty-eight students requests, nineteen were granted loans of \$1,500.00, for a total of \$28,500.00.

It is estimated that the Fund will have \$36,000.00 available for loans for the 1971-72 school year. Of this amount, \$16,500.00 is committed to prior applicants, leaving \$19,500.00 for new student requests. Applications and inquiries received to date from qualified seniors and juniors total \$12,000.00.

This report does not reflect the additional applications expected from other qualified medical students and your Committee is also mindful of the ever-increasing tuition rates. However, at this time, it does not feel the necessity to increase the \$1,500.00 yearly loan limit.

Your Committee has had continued encouraging results from its solicitation of past loan recipients now serving an internship or residency to initiate early repayment of their loans on an interest-free basis.

The financial activities of the Fund during the year are included in the report of the Treasurer.

Your Committee warmly commends and thanks Mr. Lambert and Mr. Squireck for their consistently efficient administrative assistance.

PRESENT LOCATION OF RECIPIENTS OF LOANS

The 90 graduates are located as follows:

Interns—3 in New Jersey and 3 out-of-state	6
Residents—10 in New Jersey and 26 out-of-state	36
Armed Service—18 Army of the United States and 5 United States Navy	23
Private Practice—11 New Jersey, 1 Tennessee, 1 Pennsylvania, 1 District of Columbia, 2 California, 1 Massachusetts, 3 Connecticut 2 New York, 1 Nevada, 1 Texas and 1 Virginia	25

Students presently in medical school—

15 seniors and 11 juniors	26
Current student loans outstanding	116
Medical students paid in full (61 loans)	42
Total New Jersey medical students (as listed earlier)	158

CONTRIBUTIONS

The committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

GENERAL FUND

The Medical Society of New Jersey, Board of Trustees; MSNJ's Woman's Auxiliary Executive Board; County Medical Societies: Bergen, Burlington, and Hudson. County Woman's Auxiliaries: Camden, Cape May, Cumberland, Essex, Hudson, Hunterdon, Mercer, Middlesex, Ocean, Passaic, Somerset, Union and Warren. Dr. and Mrs. Samuel Bernson, Dr. and Mrs. Alexander U. Bertland, Nicholas A. Bertha, M.D., Dr. and Mrs. Ivan F. Bird, Dr. and Mrs. A. Guy Campo, Dr. and Mrs. Jules Cooper, Dr. and Mrs. Robert Cornwell, Dr. and Mrs. David Eckstein, Dr. and Mrs. Sol S. Ellenson, Dr. and Mrs. Sidney G. Fine, Dr. and Mrs. Leon Friedman and Family, Dr. and Mrs. Eugene Gersh, Dr. and Mrs. Charles Honig, Dr. and Mrs. Frank J. Hughes, Dr. and Mrs. Philip Jasper, Mrs. Vincenza Jasper, Dr. and Mrs. Joseph R. Jehl, Dr. and Mrs. John F. Kustrup, Jr., Dr. and Mrs. John F. Kustrup, Sr., Dr. and Mrs. Arthur C. Lawrence, Dr. and Mrs. Samuel J. Lloyd, Dr. and Mrs. Nicholas E. Marchione, Dr. and Mrs. Carl F. Meier, Mrs. Alfred D. Meneve, Dr. and Mrs. Luke A. Mulligan, Mr. and Mrs. Rich-

ard I. Nevin, Dr. and Mrs. A. Gerard Peters, Dr. and Mrs. Paul H. Pettit, Dr. and Mrs. James A. Rogers, Emanuel M. Satulsky, M.D., Dr. and Mrs. John Scilieri, Dr. and Mrs. Isadore M. Schnee, Dr. and Mrs. Joseph S. Shapiro, Dr. and Mrs. D. H. Shapiro, Mrs. Lorena G. Van Ness.

IN MEMORY OF

Mr. Simon Bash, Frank Bellnardo, M.D., Mrs. J. Harold Bennett, Mrs. Nicholas A. Bertha, William A. Blumberg, M.D., David Brone, Otto Broones, M.D., Anthony F. Caprio, M.D., Chester Chianese, M.D., Mrs. Ted W. S. Chong, Mrs. Robert J. Citrino, Mrs. John Cocchiere, Audrey Cohn, Frank J. Cronin, M.D., Mr. Gilbert J. Danaso, Mrs. Mary Grace D'Angelo, Mrs. Helen Davis, Thaddeus L. Deren, M.D., Mr. Maurice Freedman, Gennaro Giannella, M.D., Alan O. Godfrey, M.D., Raphael Goldenberg, M.D., Oscar Goldstein, M.D., Maureen Haggerty, Aaron Heisen, M.D., Mr. Charles Jent, Willard Lamnsz, M.D., Carl Menge,

M.D., Seymour Nochimson, M.D., Mrs. Florence Nolan, Andrew Ogden, M.D., Mrs. Frank Percarpio, Martin H. Perle, M.D., Mrs. Walter R. Paterson, Charles Pierce, M.D., Mrs. Elvira Raffetto, Mrs. Charles F. Rathgeber, Mrs. Rogohas Rogers, Bart Rossi, M.D., Mrs. Anna Sattler, Mrs. Royal A. Schaaf, Ned Shaw, M.D., Louis C. Shapiro, M.D., Diane Tracht, Bert J. Tucker, Mrs. Margaret Ulan, Michael Walls, Louis S. Wegryn, M.D., Abram Weiss, M.D., Mrs. Rachel Winans, Mrs. Edna Yaeger, Mrs. Walter Ziegler, Mrs. Harry Zimmerman.

IN HONOR OF

Mrs. Alexander U. Bertland, MSNJ's Woman's Auxiliary Executive Board; Dr. and Mrs. Anthony Grazier, Mrs. Donald MacLean, Robert and Marji Morrow, Mrs. Alfred F. Meneve, MSNJ's Board of Trustees; Mr. and Mrs. Irad Oxley; Passaic County Medical Society, Woman's Auxiliary; Dr. and Mrs. Joseph A. Rasso.

DISTRIBUTION OF LOANS

County of Residence	Medical School	Students	Loans Granted	
			1957-1970	1970-1971 March 31, 1971
Atlantic	Hahnemann	3	\$ 3,000.00	
	N.J. Medical	1	1,000.00	
	Pittsburgh	1	2,000.00	
	Temple	1	1,000.00	
	Tufts	1	4,000.00	
Bergen	Boston	1	1,000.00	
	Creighton	1	1,000.00	
	Hahnemann	3	5,000.00	
	Jefferson	2	1,500.00	\$ 3,000.00
	Loyola	1		1,500.00
	N.J. Medical	7	11,000.00	
	N.Y. Medical	2	1,000.00	1,500.00
	St. Louis	2	1,500.00	1,500.00
Burlington	Duke	1	4,000.00	
	Hahnemann	1	1,000.00	
	Jefferson	3	6,500.00	1,500.00
Camden	Jefferson	3	5,000.00	
	Michigan	1	2,000.00	
	N. J. Medical	2	2,700.00	
	Temple	5	7,500.00	
	Hahnemann	3	2,000.00	1,500.00
Cumberland	Jefferson	1	2,000.00	
Essex	Albany	1	4,000.00	
	Bern	1	2,000.00	
	Duke	1	2,000.00	
	Hahnemann	3	8,000.00	
	Howard	1	300.00	
	Jefferson	1	3,000.00	
	N.J. Medical	12	20,500.00	4,500.00
	N.Y. Medical	2	2,000.00	
	Stanford	1	1,500.00	1,500.00
	St. Louis	1	500.00	
	Temple	1	1,000.00	
	Georgetown	1	1,000.00	
Gloucester	Hahnemann	1	1,000.00	
	Temple	1	2,000.00	
	U. of Virginia	1	1,000.00	
Hudson	Georgetown	1	1,000.00	
	George Washington	1	1,500.00	1,500.00
	Harvard	1	1,000.00	
	Howard	1	400.00	

County of Residence	Medical School	Students	Loans Granted	
			1957-1970	1970-1971 March 31, 1971
	Hudson N.J. Medical	19	26,150.00	1,500.00
	N.Y. Medical	1	1,000.00	
	Pittsburgh	1	3,000.00	
	St. Louis	1	2,000.00	
Mercer	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Johns Hopkins	1	1,000.00	
	Meharry	1	250.00	
	Mississippi	1	3,000.00	
	N.J. Medical	5	9,500.00	
	N.Y. Medical	1	1,500.00	
	U. of Penna.	1	1,000.00	
	St. Louis	1	700.00	
	U. of Louisville	1	3,000.00	1,500.00
Middlesex	Georgetown	1	1,500.00	
	Hahnemann	1	4,000.00	
	Wisconsin	1		1,500.00
Monmouth	Columbia	1	2,000.00	
	Duke	1		1,500.00
	Georgetown	1	1,000.00	
	Jefferson	2	3,000.00	1,500.00
	Marquette	2	3,500.00	
	N.J. Medical	3	10,000.00	
	N.Y. Medical	1	4,000.00	
	Loyola	1	1,500.00	1,500.00
	Temple	1	2,000.00	
	Up-State N.Y.	1	1,000.00	
Morris	Dartmouth	1	1,000.00	
	Duke	1	1,000.00	
	Loyola	1		1,500.00
	N.J. Medical	1	3,000.00	
Passaic	Jefferson	1	3,000.00	
	N.Y. Medical	1	1,000.00	
Salem	Duke	1	1,500.00	
Somerset	Georgetown	1	1,000.00	
	N.Y. Medical	1	2,000.00	
	Temple	1	3,000.00	
	Western Reserve	1	1,000.00	
Union	Florida	1	1,000.00	
	Hahnemann	1	1,000.00	
	Jefferson	1	1,500.00	
	N.J. Medical	11	17,800.00	
16 Counties	31 Medical Schools	158	\$247,800.00	\$28,500.00
Total loans granted 3/31/71				\$276,300.00

Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee—approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1971-72 in support of the Medical Student Loan Fund.

(b) That the MSNJ membership be urged to

continue their active support by sending contributions to the Fund.

(c) That the Woman's Auxiliary to The Medical Society of New Jersey be requested to make the Fund its number one project next year.

Approved (page Tr 133)

Publication

George B. Sharbaugh, M.D., Chairman, Trenton

(Reference Committee "B")

Trends established as early as 1966 continue to prevail as *The Journal*, along with all medical journal publishers, faces decreasing advertising receipts in consequence of general industry conditions as well as tighter FDA standards. FDA standards adversely affecting advertising budgets include increasing caution in approval of new products as well as advertising content requirements, e.g., full disclosure of side effects.

The Journal's new policy of interspersal of advertising and text appears to help our market position to the extent that our make-up allows us to be competitive with all other journals.

The Journal is publishing an ever increasing ratio of "text" material—defined as "everything except advertising." Our proportion of "text" to total pages has increased during the past four years and in 1970 reached the high of 57 per cent. This is only partly due to a decrease in advertising pages, as we increase the number of scientific articles and other pages devoted to information for our members.

The most noticeable statistic reflected in the table below is unquestionably the increase in "text" pages from 578 in 1966 to 752 in 1970.

	1966	1967	1968	1969	1970
Total Text Material	578	704	708	720	752
Advertising	660	788	714	616	556
Total Pages	1238	1492	1422	1336	1308
Ratio: Text/Total	47%	47%	50%	54%	57%
Ratio: Advertising/Total	53%	53%	50%	46%	43%

Our rates were increased in 1970, as were our publication costs. It is too early to determine accurately how rate increases/fewer pages on the income side of the ledger will offset spiraling printing costs.

Reasons for addition in the number of pages of text include the following. The "Doctors'

Notebook" section has been enlarged to contain, in addition to monthly commitments (such as the abstract of the Trustees' minutes and "Physicians Seeking Location in New Jersey"), an increasing number of items of interest to our members, some at the direction of the Board of Trustees (included here are requests from MSNJ Councils and/or Committees); some from the College of Medicine and Dentistry; some from the State Department of Health; and some by decision of the editor. To present a better balanced publication we have extended, slightly, the number of pages of scientific articles.

There has been increased interest in "Letters to the Editor"—we received double the number of the previous year. The May 1971 issue is, in effect, a special educational issue.

We must call attention to the practice of charging the publication cost of the Transactions Issue entirely to *The Journal*. That one issue, last year, ran \$9,500. But June of that year cost only \$4,250. To some extent this also applies to the April issue, which includes the annual meeting program. We use special paper, and the cost of setting the pages of that section is considerably more than for regular text. It runs about \$1,500 above that of other issues. The increase in advertising in those two issues is *not* at the same ratio.

We probably have the lowest overhead cost and the most modest administrative staff of any periodical our size—only one full-time employee, Mrs. Treptow, and the part-time editor and advertising manager. We think we do a prodigious job with so small a staff.

Approved with notation (page Tr 133)

Revision of Constitution and Bylaws

Lorrimer Armstrong, M.D., Chairman, Westfield
(Reference Committee on Constitution and Bylaws)

This year the Committee had several proposals before it and dealt with each separately and in detail according to its assigned functions under the Bylaws (Chapter IX, Section 17, b).

REFERRAL FROM THE 1970 HOUSE OF DELEGATES

The 1969 House of Delegates suggested that consideration be given to changing the standard scheduling of events at the Annual Meeting. A proposed amendment mandating that the Nominating Committee meet within the two week period prior to the opening session of the House of Delegates was submitted. At the 1970 Annual Meeting, the Reference Committee on Revision of Constitution and Bylaws altered that proposal to mandate that the Nominating Committee meet at least four to six weeks prior to the opening session of the House of Delegates and that the results of their deliberations be circulated to the component societies prior to the Annual Meeting.

The 1970 House of Delegates did not approve of the amended proposal and recommended it to the Standing Committee on Revision of Constitution and Bylaws.

After careful consideration of both former proposals, it was the opinion of this Committee that the present arrangement and procedure as outlined in the Bylaws is satisfactory. The Committee, by unanimous agreement offers the following:

Recommendation

That the Bylaws—Chapter V, Section 1, paragraph (d)—remain the same until the advantages of any change become more clearly defined and the House of Delegates, by major-

ity decision, directs a definite and specific amendment.

Approved (page Tr 146)

REFERRALS FROM THE BOARD OF TRUSTEES

1. *Physicians' Relief Fund* (Bylaw Amendment)

The Committee reviewed the recommendations of the committee on the Establishment of a Physicians' Relief Fund and the proposed amendment offered by the Board of Trustees and unanimously *recommends* that the amendment to the Bylaws Chapter IX, Section 17, *et seq.* be adopted.

Exhibit #1

Chapter IX—Administrative Councils and Committees

Current

Proposed

Section 17—Committee on Physicians' Relief Fund

(a) *The Physicians' Relief Fund of this Society shall be administered by a committee of five (5) members appointed by the Board of Trustees, one (1) from each Judicial District for terms of three (3) years. Their terms shall be so arranged that not more than two (2) expire at each annual meeting.*

(b) *It is the function of the committee to administer the Physicians' Relief Fund program in accordance with the rules and regulations formulated by the committee and approved by the Board of Trustees.*

Section 17—Committee on Publication

Section 18—Committee on Publication

Section 18—Committee on Revision of Constitution and Bylaws

Section 19—Committee on Revision of Constitution and Bylaws

Section 19—Advisory Committee to the Woman's Auxiliary

Section 20—Advisory Committee to the Woman's Auxiliary

Section 20—Special Committees

Section 21—Special Committees

Section 21—Reference Committees

Section 22—Reference Committees

Approved (page Tr 146)

2. Appointment of Vice-Speaker (Constitutional Amendment)

The Committee unanimously agrees to the following proposed amendment to Article V, Section 2 of the Constitution as submitted by the Board of Trustees.

Exhibit #2

Article V—House of Delegates Section 2—Speaker

Current	Proposed
Speaker	Speaker and Vice-Speaker
The President shall have the power to appoint a Speaker of the House of Delegates at each annual meeting. The Speaker shall be a member of this Society, and his sole duty shall be to preside at the sessions of the House of Delegates. He shall not have the power to appoint committees.	Same

The President shall also have the power to appoint a Vice-Speaker of the House of Delegates at each annual meeting. The Vice-Speaker shall be a member of this Society, and his duty shall be to assist the Speaker in presiding at the sessions of the House of Delegates. He shall not have the power to appoint committees.

Approved (page Tr 146)



Fellow—Jesse McCall and Mrs. McCall.



Fellow—John Kustrup and Mrs. Kustrup.



Fellow—Louis Collins and Mrs. Collins.

Woman's Auxiliary Advisory

William J. Roe, M.D., Chairman, Englewood

(Reference Committee "H")

At its July 1970 meeting, the Board of Trustees approved the Proposed Program of the Woman's Auxiliary for 1970-1971 as submitted. Because the work of the Auxiliary was so well planned and so smoothly carried out there was no need for a formal meeting of this Committee in the course of the administrative year.

Also at its July meeting, the Board of Trustees—in the interest of increasing attendance at the First Session of the House of Delegates (on Saturday, 15 May 1971) and of improving the number of visitors to the exhibits at the 205th Annual Meeting—made the following recommendation to the Executive Board of the Woman's Auxiliary:

a. That the Woman's Auxiliary change its schedule of registration to coincide with that of MSNJ—10:00 a.m., Saturday, 15 May 1971. It was agreed that the registration hours of the Auxiliary would be from 12:00 noon until 4:00 p.m., Saturday, 15 May 1971.

b. That the Woman's Auxiliary registration area be located in the Exhibit Hall adjacent to MSNJ's registration, rather than in the hotel lobby. In addition, an information desk will be set up at the former location in the hotel lobby.

c. That the Woman's Auxiliary Art Exhibit be located in the Exhibit Hall adjacent to the Auxiliary registration area.

d. That the Woman's Auxiliary plan more activities for their members on Tuesday in an effort to hold them in Atlantic City until the close of the final session of the House of Delegates on that day.

The Executive Board agreed to adopt all the recommendations, and the Board of Trustees expressed its appreciation.

All programs and activities of the Woman's Auxiliary are adopted and adapted to support the purposes and programs of The Med-

ical Society of New Jersey. No Auxiliary activity is entered upon—at State and county levels—except with the approval and in cooperation with the parent medical society.

This year the Woman's Auxiliary attained its goal of an auxiliary in each of the 21 counties of the State. The Woman's Auxiliary to the Sussex County Medical Society was organized, with 95 per cent of the doctors' wives attending the first regular meeting.

In the year now closing top priority has been given by the Auxiliary to the Medical Student Loan Fund of MSNJ, to the AMA-ERF, Health Careers, and Community Health Programs, with emphasis on blood donor programs. This year Mrs. Walter Booth and her Committee on Revisions have labored ardently and efficiently on the preparation of a comprehensive revision of the Auxiliary's By-laws, for submission to the membership at the General Session on 17 May.

This year Mrs. Alexander Bertland, following the precedent of other years, as President of the Auxiliary, will by invitation present a report to the House of Delegates of MSNJ at its First Session on 15 May.

The Committee applauds the Woman's Auxiliary for its fine work and accomplishments and extends sincere thanks, in the name of The Medical Society of New Jersey, to officers and members alike.

Approved with notation (page Tr 145)

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Administrative Council

Legislation

Jesse McCall, M.D., Chairman, Newton

(Reference Committee "E")

Beginning with January 1970, each Legislature in New Jersey is constituted for a term of two years. Therefore, all bills introduced since January 1970, not signed into law or absolutely vetoed, will continue to be before the Legislature until the beginning of the next two year session in January 1972. This report will present lists of bills of medical interest already considered by the House in 1970, and recorded in the 1970 transactions, which have, up to the present, been either signed into law or vetoed. It will also present a complete list of bills of medical interest that have been introduced, and concerning which the Society has taken a position, since the 1970 report to the House of Delegates.

The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislators and Legislative Kevmen and to component societies, and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings. The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings. Although a copy of a memorandum announcing the date of the Council's next meeting is sent to all MSNJ's Official Intermediaries with New Jersey Specialty Societies, the attendance of the representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

Of the bills reported to the House in 1970 . . .

(A) Two (2) that were *ACTIVELY SUPPORTED* were signed into law:

S-559—To give confidentiality to data secured by utilization review committees, and immunity from suit to such committee members.

S-573—To provide for reporting by physicians and persons affected of individuals found subject to seizures and blackouts not controllable by medication.

(B) Eighteen (18) bills that were *APPROVED* were signed into law:

S-182, S-259, S-293, S-404, S-405, S-407, S-409, S-410, S-422, S-647, S-688, S-700, A-6, A-245, A-589, A-795, A-828 and A-887

(C) One (1) bill that was *ACTIVELY SUPPORTED* lost in the Assembly:

A-802—To legalize the use by physicians of qualified technical ancillary personnel to carry out specific, limited procedures on patients.

(D) One (1) bill that was *APPROVED* was vetoed:

A-251—To require an English-speaking attendant in every hospital emergency room capable of interpreting in the language of the licensed medical practitioner in charge of such room.

N.B. No bills that were *ACTIVELY OPPOSED* or *DISAPPROVED* were signed into law at the time of compilation of this report.

CURRENT STATE LEGISLATION

(This list presents bills of medical interest that have been introduced, or concerning which the Society has taken its position, since the 1970 report to the House of Delegates. This list continues, therefore, where the 1970 report leaves off.)

The Society uses the following regular range of official positions concerning proposed legislation:

Active Support . . . All-out support for the measure
 Active Opposition . . . All-out opposition to the measure
 Approved . . . Commended as satisfactory, but not actively supported
 Disapproved . . . Rejected as unsatisfactory, but not actively opposed
 No Action . . . Considered, but not regarded as significant or relevant to the proper interests of the Society

S-747 —To establish proceedings for the protection of children under 16 years of age who have had serious physical or mental injury inflicted upon them by other than accidental means. *APPROVED*

S-752— Provides that blood, blood plasma or tissue or organs shall not be considered commodities subject to sale or barter. *ACTIVE SUPPORT*

S-757 —To provide that it shall be unlawful for any person, firm, or corporation to advertise or solicit eye examination or visual services or advertise for sale eyeglasses, lenses, frames, mountings, prisms or other optical appliances by newspapers, billboard, radio, television, window display or other means or to use any method of persuading the public to buy visual correction services. *DISAPPROVED*, on the grounds that the end result would be economically against the public interest and discriminatory against manufacturers and suppliers of lenses and prisms who would provide these articles at lower costs.

S-786 —To provide that it shall be unlawful for ophthalmic dispensers or technicians to advertise or employ displays in such a way as to suggest they are qualified to give professional advice concerning eye care. *APPROVED*

S-810 —To provide that it shall be a high misdemeanor for any person to add any narcotic, stimulant, depressant or hallucinogenic drug or substance to any food, beverage or other comestible, and punishable by imprisonment for not less than 10 years or a fine of not more than \$5,000 or both. *APPROVED*

S-817 —To authorize the Department of Environmental Protection to establish pre-treatment standards for sewage that may be discharged into public sewage treatment plants. *APPROVED*

S-821 —To provide that physicians, pharmacists, nurses, veterinarians and similar persons shall be exempt from provisions of the act concerning unlawful sale or possession of prescription drugs when they are acting in regular course of their business or profession. *APPROVED—Law-C.38 (71)*

S-838 —To provide any employee, holding the degree of M.D., regularly employed by a duly licensed hospital may, upon application to the State Board of Medical Examiners, be granted an exemption from provisions of the act concerning medicine and surgery provided such employee is limited to performance of emergency medical service under the direct supervision of a duly licensed physician.

DISAPPROVED because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.

S-851 —To provide for the New Jersey Controlled Dangerous Substances Act to be administered by the Commissioner of Health. *NO ACTION—LAW-C.226*

The Council took the above position because no official copy was available for analysis and appreciation prior to its enactment into law.

S-872 —To provide that the definition of "pharmacy" and "drugstore" shall include every place in which drugs, prescriptions and poisons are possessed for compounding and dispensing at retail; to provide that such definition shall not include the dispensing of drugs in a hospital, nursing home, convalescent center, industrial dispensary, medical clinic or similar institution where such are dispensed under an institutional permit to inpatients, employees, and outpatients. *NO ACTION*

S-875 —To provide comprehensive revision to the Act for the uniform control and licensing of dogs and kennels to aid in preventing the spread of rabies. *APPROVED*

S-884 —To authorize the establishment and maintenance of a confidential registry of narcotic addicts and drug abusers and provides immunity against suit to any person providing information on the use or users of drugs. *APPROVED—Law-C.227*

S-896 —To appropriate \$100,000 to the Department of Health for administration of renal diseases program. *APPROVED*

S-913 —To provide that any person 18 years of age or over can donate blood in any voluntary and non-compensatory program without obtaining parental permission. *APPROVED*

S-949 —To provide that a standard serological test for syphilis shall be a test approved by the Department of Health and shall be made in approved laboratories; to permit such laboratory tests to be made free of charge by the Department of Health. *APPROVED*

S-951 —To provide for the licensing of medical care facilities and to transfer certain powers and duties from the Department of Institutions and Agencies to the Department of Health. *DISAPPROVED*, because of Section 16 which would empower Hospital Service Corporations to enter into contracts for the rendering of Medical-Care Services which should be restricted to Medical Service Corporations.

S-956 —To abolish the State Board of Control of Institutions and Agencies and transfer its functions, powers and duties to the Department of Institutions and Agencies and to create therein a State Advisory Council. *DISAPPROVED*, because there is no evidence that a change in the organizational structure would result in the improvement of the operational functions of the present system.

- S-960 —To appropriate \$75,000 to the Department of Health for purchase of therapeutic and educational materials for distribution for the treatment of venereal disease. *APPROVED*
- S-977 —To provide a supplementary appropriation of \$1,629,871 for the New Jersey College of Medicine and Dentistry for the fiscal year ending June 31, 1971. *APPROVED*
- S-981 —To provide for the establishment of a central registry of blood donors in the State Department of Health and to appropriate \$50,000. *DISAPPROVED*, because it would be a duplication of record keeping by existing blood banks in the State of New Jersey, with no appreciable advantages.
- S-982 —To prohibit application of lead paint to toys, furniture or the interior surfaces of any dwelling, dwelling unit, rooming house, rooming unit or facility occupied or used by children, and to prohibit sale or delivery of toys or furniture to which lead paint has been applied. *APPROVED*
- S-993 —To amend and supplement the "New Jersey Controlled Dangerous Substances Act". *APPROVED—LAW-C.3 ('71)*
- S-994 —To permit freeholders to contract with duly incorporated charitable organizations for maintenance of narcotic treatment programs. *APPROVED*
- S-998 —To prohibit application of lead paint in interior of dwelling in which children reside and to prohibit sale, transfer, or delivery of toys and furniture which have lead paint. *APPROVED*
- S-2015 —To provide that all members of professional boards and commissions shall be appointed by the Governor, to provide for an additional member to such boards and commissions who shall be a public member, and to provide for designation by the Governor of a head of a department closely related to such professions to be a member of the boards or commissions. *ACTIVE OPPOSITION*, because professionally unqualified lay members would encumber the boards with no appreciable advantage to the public and the present system of nomination of members to the State Board of Medical Examiners is superior to that proposed. *LAW-C.69 ('71)*
- S-2032 —To remove the residency requirement for county medical examiners. *APPROVED*
- S-2057 —To authorize boards of education to provide sex education from pupils in 7th through 12th grades. *DISAPPROVED*, because it would prevent any program of sex education below the 7th grade, where it is most needed.
- S-2069 —To authorize the control of community noise levels; empowering the State Department of Environmental Protection to promulgate regulations for such purpose, and making an appropriation. *APPROVED*
- S-2076 —To provide that any person who smokes in a railroad passenger car in which a "No Smoking" sign is posted is a disorderly person. *APPROVED*
- S-2083 —To permit licensing of graduates of foreign medical schools to practice medicine in the United States after one year of internship in a hospital. *DISAPPROVED*, because the bill as drawn does not assure the purpose for which the legislation is intended—namely, to increase the number of interns and residents in New Jersey hospitals.
- S-2084 —To provide that applications for commitment for treatment of drug addiction by minors shall be valid and binding as if the minor had attained the age of 21 years. *APPROVED*
- S-2088 —To provide for a Health Care Administration Board in the Department of Health with the Commissioners of Health and Insurance as ex-officio members, to authorize the Commissioner of Health to inquire into the operation and conduct inspections of medical care facilities, to adopt regulations, to provide for licensing and to transfer all functions related to administration of laws concerning boarding homes for sheltered care, care of children and adults, private mental hospitals, convalescent homes, private nursing homes and private hospitals from the Department of Institutions and Agencies to the Department of Health. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES*, because it poses a threat to the free practice of medicine, concentrates excessive power in the hands of one person, and jeopardizes the continuance of the life and operation of the Medical-Surgical Plan of New Jersey (New Jersey Blue Shield).
- S-2091 —To redefine "unnecessary radiation" under the "Radiation Protection Act"; to provide for the Commission of Radiation Protection in the Department of Environmental Protection in place of the Department of Health and to permit an embargo of any material or machine which is a radiation hazard. *APPROVED*
- S-2100 —To delete provisions of the New Jersey Medical Assistance and Health Services Act providing for payment of claims through a fiscal agent or by direct administration by the Department of Institutions and Agencies. *NO ACTION*
- S-2103 —To permit any minor suffering from use of drugs and who is dependent upon drugs to consent to medical treatment. *APPROVED*
- SJR-2001 —To create a commission to ascertain and devise the most practicable method of establishing a judicial mechanism for dealing with drug addicts and others whose personal accountability for their actions is impaired by their psychological condition. *NO ACTION*
- SJR-2003 —To declare the month of May, 1971 as "Venereal Disease Awareness Month." *APPROVED*
- A-496 —To provide for regulation of use of safety glazing material and to direct the Commissioner of Labor and Industry to promulgate safety standards. *APPROVED*
- A-506 —To eliminate the requirement of a medical examiner's investigation in death cases occur-

ring within 24 hours after admission to a hospital or institution and to eliminate the need for personal presence of the Medical Examiner, his deputy or assistant at the scene of the death requiring investigation. *APPROVED*

A-915 —To authorize the Director of Health to establish a program for immunization of citizens against rubella disease. *APPROVED*

A-921 —To provide for rubella inoculation for school children. *APPROVED*

A-922 —To prohibit erection of billboards, neon signs or commercial advertising within 300 feet of a traffic sign, signal or intersection along any State or county highway. *APPROVED*

A-929 —To permit noncitizens to be registered as physical therapists. *DISAPPROVED* because, as for foreign physicians, the declaration of intent to become a citizen is a method open to such individuals to qualify for registration and therefore, this legislation is not necessary.

A-937 —To permit courts, upon application after a lapse of five years after conviction, to expunge the record of first offenders 25 years of age or younger, who have been convicted of possession of marihuana. *APPROVED*

A-941 —To require the licensing, inspection, and regulation of medical care facilities; to provide for issuance of certificates of need by the Commissioner of Institutions and Agencies for construction and expansion of medical facilities; to provide for enforcement by the Department of Institutions and Agencies. (Substitute for A-200 of 1970) *NO ACTION* —*VETOED*

A-946 —To authorize the confinement of insane persons and those acquitted of crime because of insanity to a New Jersey state hospital to be designated by the Commissioner of Institutions and Agencies. *APPROVED*

A-957 —To direct the Board of Education to require immunization of all pupils against rubella as a condition for entrance to kindergarten and grades one through four. *DISAPPROVED* because it should be up to the individual Board of Education whether immunization against rubella is to be obligatory.

A-960 —To provide that the selling of alcoholic beverages to minors shall be a disorderly persons offense in place of a misdemeanor. *APPROVED*—LAW-C.54 (71)

A-967 —To regulate and control the manufacture, handling, sale and distribution of dangerous substances under the administration of the Department of Health. (Substantially the same as S-851 of this year.) *ACTION DEFERRED*

A-980 —To create a Population Environment Council consisting of the Commissioners of Environmental Protection, Labor and Industry, Education, Health and Community Affairs and seven citizens to conduct or cause to be con-

ducted studies of the range of problems associated with population growth and related demographic changes. *NO ACTION*

A-988 —To establish the "Open Space Preservation Law" and to create a New Jersey Open Space Council in the Department of Environmental Protection. *APPROVED*

A-989 —To provide that the Department of Environmental Protection shall have authority to adopt and promulgate rules and regulations concerning the pollution of the air, earth and water of the State. *APPROVED*

A-993 —To define "physical therapy" or physiotherapy, to provide for approval of the required course of study by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; to require applicants for registration to pass an examination provided by the American Public Health Association or the Physical Therapy Examining Board which is created in the Division of Professional Boards and other amendments. *ACTION DEFERRED*

A-994 —To permit the Governor to issue a proclamation for apprehending any person, not a narcotic addict and over age 21 on charges—on oath by one or more credible witnesses—of having sold, given, administered or dispensed any hard drugs, or any person aiding such person, and to permit a reward not exceeding \$500 for any one person. *NO ACTION*

A-1020 —To provide for the control and regulation of use and application of pesticides, to require registration and to establish "The Pesticide Act." *APPROVED*

A-1034 —To provide for labeling of horsemeat by persons who transport, other than a common carrier, sell or offer such for sale to be effective when the Governor suspends operation of the New Jersey Meat and Poultry Inspection Act. (Companion measure to A-1035) *APPROVED*

A-1035 —To permit the Governor to suspend operations of the "New Jersey Meat and Poultry Inspection Act" upon notification that the United States Department of Agriculture intends to extend provisions of the Federal Meat Inspection Act to operations and transactions wholly within this State. (Companion measure to A-1034) *APPROVED*

A-1037 —To permit boards of education to apply to the Commissioner of Education for approval of programs of education for adults in regard to the use of narcotics. *APPROVED*

A-1054 —To appropriate \$50,000 to the Department of Education for supervision of teacher training and instructional programs in connection with drug education programs for 610,000 students in secondary school districts.—*APPROVED*

A-1056 —To authorize the Commissioner of Education to establish summer workshop and training programs to train selected teachers to teach a drug education program to secondary school

teachers; to provide that the programs shall be under the direction of persons designated by the Commissioner—including representatives of the Departments of Education, Higher Education, Rutgers University, College of Medicine and Dentistry of New Jersey and the Urban Schools Development Council. *APPROVED—LAW-C.85*

A-1059—To combine the Rutgers Medical School and the New Jersey College of Medicine and Dentistry into a single entity to be known as the College of Medicine and Dentistry of New Jersey, to transfer thereto all employees of the two medical schools, all files, books, records and equipment and all appropriations available and to become available. *APPROVED—LAW-C.102*

A-1060—To appropriate \$315,000 to the Department of Education for grants to secondary school districts in operation of drug education programs to be allocated on the basis of enrollment as of September 30, 1970 according to a formula as determined by the Commissioner. *APPROVED*

A-1061—To appropriate \$175,000 to the Department of Education to establish summer workshops and training programs to train selected teachers to teach a drug education program to secondary school teachers. *APPROVED—LAW-C.86*

A-1062—To appropriate \$500,000 to the Department of Health for the purpose of matching Federal funds for the continuation and expansion of the New Jersey Regional Drug Abuse Agency. *PROVED—LAW-C.87*

A-1063—To appropriate \$130,000 to the Department of Health for the purpose of broadening the experimental methadone maintenance treatment programs operated by the New Jersey Neuro-Psychiatric Institute at Skillman. *APPROVED—LAW-C.126*

A-1064—To appropriate \$40,000 to the Department of Institutions and Agencies for the purpose of employing selected teachers in summer programs in connection with the clinical aspects of drug addiction and rehabilitation in the State's institutions and agencies. *APPROVED*

A-1082—To permit discharges of sewage and other wastes into the Delaware River only if they conform to regulations of the Department of Health and will not kill or injure fish, birds or mammals, to take effect upon similar enactment by the Commonwealth of Pennsylvania. (Companion measure to A-1083) *APPROVED*

A-1083—To permit discharges of sewage and other wastes into the tidal waters of the State only if they conform to regulations of the Department of Health and will not kill or injure fish, birds or mammals. (Companion measure to A-1082) *APPROVED*

A-1084—To grant physicians, teachers and other personnel immunity from civil suit for damages for good faith actions in relation to persons addicted to or illegally using narcotic drugs. *APPROVED*

A-1099—To provide that the Commissioner of Health may waive the requirement of an examination and a public health degree for a health officer's license where a person holds an M.D. or D.D.S. degree, has been licensed by the State, has experience for 15 years and completed residency requirements. *DISAPPROVED* in adherence to the policy position taken by the House of Delegates of MSNJ in 1961 and because such legislation would be a retrogressive step in public health in New Jersey.

A-1104—To define "unnecessary radiation" in the Radiation Protection Act; to add one more member to the Commission, to permit placing an "embargo" on machines considered a radiation hazard. *APPROVED*

A-1119—To limit the practice of ophthalmic dispensing to licensed ophthalmic dispensers. *DISAPPROVED* because it would be an unnecessary restriction on the practice of optometry and the practice of medicine by duly licensed persons without a concomitant benefit to the public.

A-1128—To prescribe standards and requirements for emergency stopping systems for motor vehicles using air brakes. *APPROVED*

A-1133—To authorize school districts to conduct a non-binding referendum approving or disapproving proposed sex education programs in any public school before any such program may be implemented. *NO ACTION*

A-1135—To provide for penalties concerning selling, dispensing or giving away of marijuana and other narcotic drugs. *NO ACTION* (in view of enactment of S-851)

A-1163—To empower the board of trustees of the College of Medicine and Dentistry of New Jersey to acquire the Newark City Hospital. *APPROVED*

A-1184—To appropriate \$100,000 to the Department of Education for teacher training projects, community drug education programs and for mobile classrooms for drug education programs. *APPROVED—LAW-C.228*

A-1186—To abolish the requirement that the driver of a motor vehicle must give an audible warning by horn before passing another vehicle proceeding in the same direction. *APPROVED*

A-1198—To regulate the sale of non-prescription drugs containing ethyl alcohol, dextromethorphan, phenobarbital, etc. *APPROVED*

A-1203—This bill would transfer all powers, duties and responsibilities of the State Board of Control, the Hospital Licensing Board, the Commissioner of Institutions and Agencies and the Department of Institutions and Agencies related to medical care facilities to the State Department of Health. (Substitute for A-941) *APPROVED*

A-1207—To require approval, inspection and regulation of narcotic treatment centers by the Commissioner of Health. *APPROVED—LAW-C.334*

- A-1211—To establish a state-wide system of Drug Abuse Treatment and Counseling Clinics under the direction of the Commissioner of Health. *APPROVED*
- A-1213—Requires the written consent of a parent or guardian of a pupil, and of a physician of the parent's or guardian's choice, prior to the administration to a pupil by public school authorities of any drug or medication for experimental purposes or for stimulating the learning process. *APPROVED*
- A-1216—To direct the Commissioner of Health to combat lead poisoning in children and to appropriate \$100,000. *NO ACTION*
- A-1219—To appropriate \$240,000 to the Department of Education for additional expenses incurred in the operation of drug education programs in secondary schools, for implementation of teacher training programs and acquisition of audio-visual equipment. *APPROVED—LAW-C.229*
- A-1236—To authorize the Commissioner of Health to provide for the care and treatment of drug addicts by public and private facilities, including out-patient care and rehabilitation treatment and to appropriate 300,000. *APPROVED*
- A-1252—To add the Commissioner of Health to the Board of Trustees of the College of Medicine and Dentistry of New Jersey. *APPROVED—LAW-C.311*
- A-1258—To provide that no person shall be fitted with footwear while barefoot and to provide that anyone who violates this act shall be a disorderly person. *NO ACTION*
- A-1260—To provide that no person shall distribute, sell or deliver any eye glasses or sun glasses unless they are fitted with heat-treated glass lenses, plastic lenses or laminated lenses and capable of withstanding an impact test of a $\frac{5}{8}$ " steel ball dropped fifty inches and to provide that no person may fabricate, sell or have in his possession frames manufactured from cellulose nitrate or other highly flammable materials. *DISAPPROVED*, because Section 3 of the bill is much too broad and might result in an undue economic burden.
- A-1271—To provide that the consent of a minor who is suffering from mental illness to provisions of medical or mental health care or services shall be valid and binding. *DISAPPROVED*, because the bill, as written, is inherently unsound in that it calls for reliable judgment from an individual who by definition is incapable of rendering the same.
- A-1291—To provide for the regulation of mass gatherings and for the establishment in the State Department of Health of a Mass Gathering Review Board. *APPROVED*
- A-1295—To provide that no person shall apply lead paint to toys, furniture or the interior surfaces of any dwelling, dwelling unit, rooming house, rooming unit or facility occupied or used by children; to authorize the Commissioner of Health to promulgate rules and regulations and to institute legal action if he finds that any municipality is not enforcing provisions of this act. *APPROVED*
- A-1307—To provide for a New Jersey Controlled Dangerous Substances Act. *NO ACTION* (in view of enactment of S-851)
- A-1312—To appropriate \$1,000,000 to the Department of Health for family planning and related services. *NO ACTION*
- A-1323—To prohibit the littering of waterways and adjacent shores and beaches and to regulate marine toilets and to repeal Chapter 13, P.L. 1954 and Chapter 170, P.L. 1958. *APPROVED*
- A-1337—To require all persons riding in the front seat of an automobile manufactured after July 1, 1966 to wear seat safety belts. *DISAPPROVED*, because there are certain medical conditions in which the wearing of seat belts is contraindicated.
- A-1354—To require public school buses and other motor vehicles used to transport children to and from school to be equipped with seat belts for every seat. *APPROVED*
- A-1386—To provide for the regulation and control of pesticides by the Department of Environmental Protection and to establish a Pesticide Control Council. *APPROVED*
- A-2001—To permit blind persons with trained seeing-eye dog guides to enter into all public places. *APPROVED*
- A-2037—To provide that no person shall store or drain or dispose of dangerous or toxic chemicals in or on the soil unless the soil is protected by a dike or shield and unless an annual permit is obtained from the Commissioner of Environmental Protection. *APPROVED*
- A-2038—To prescribe criminal penalties for atrocious assault and battery on police, firemen, volunteer firemen and ambulance, rescue, first-aid or emergency squad personnel. *APPROVED*
- A-2039—To provide for appointment of a member of the New Jersey Industrial Nurses Association to the State Board of Examiners of Nurses. *NO ACTION*
- A-2055—To provide that the State Rehabilitation Commission shall administer a program of vocational rehabilitation to severely handicapped persons and shall institute and administer a program of extended employment in a sheltered workshop. *APPROVED*
- A-2056—To delete the requirement that the county medical examiner shall be a resident of the county in which appointed. *APPROVED*
- A-2060—To create the New Jersey Medical Education Loan Fund in the Department of Higher Education. *ACTIVE SUPPORT*
- A-2061—To provide that the Board of Nursing shall not suspend a temporary permit to any foreign nurse to practice professional nursing solely because such nurse failed to pass a nursing examination given by the Board. *NO ACTION*

- A-2073—To require issuance of a plenary license to practice medicine and surgery to persons achieving a 75% average in examinations given by the Medical Examining Board. *ACTION DEFERRED*, because this measure eliminates the discretionary powers of the State Board of Medical Examiners. The Council referred this bill to the State Board of Medical Examiners for its opinion.
- A-2079—To authorize the Public Utilities Commission to regulate and control radioactive material, waste and by-product material and to provide for licensing and filing of annual reports. *DISAPPROVED*, because this bill is in conflict with C. 33 of the Laws of 1970, transferring power to control unnecessary radiation from the Department of Health to the Department of Environmental Protection.
- A-2094—To permit medical payments for children in foster homes, where placed by private non-profit agencies, under the medical assistance program. *APPROVED*
- A-2098—To provide that illnesses caused by hypertension, heart disease, tuberculosis, including coronary thrombosis, shall be deemed an occupational disease of fire and policemen. *DISAPPROVED*, because this bill involves diagnosis by legislation rather than by medical examination.
- A-2099—To provide that under C. 253, P.L. 1944, hypertension, heart disease, tuberculosis suffered by fire and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED*, because this bill involves diagnosis by legislation rather than by medical examination.
- A-2100—To provide under C. 253, P.L. 1944, that hypertension, heart disease, tuberculosis suffered by fire and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED*, because this bill involves diagnosis by legislation rather than by medical examination.
- A-2102—To permit examination of person for a bio-analytical laboratory director's license who demonstrates that he has acquired through experience or through experience and schooling the requirements set forth in the Bio-analytical Laboratory and Laboratory Director's Act. *DISAPPROVED*, because there is no justification for the lowering of standards provided by existing statutes, since these standards are essential for the protection of the public.
- A-2107—To require labeling of any soap, soap powder or detergent as to its phosphate content; declares any violator a disorderly person. *APPROVED*
- A-2115—To provide that possession of more than 5 grams of marijuana or any amount of hashish shall be a high misdemeanor. *NO ACTION*
- A-2122—To delete provisions of the New Jersey Medical Assistance and Health Services Act providing for payment of claims through a fiscal agent or by direct administration by the Department of Institutions and Agencies. *NO ACTION*
- A-2131—To provide that no hospital which receives funds under the Medical Assistance and Health Services Act shall require as a condition to serving an internship an examination other than that required by the State Board of Medical Examiners. *DISAPPROVED*, because enactment of this legislation could ultimately result in the withdrawal of approval of all internships and residencies in the hospitals that act in accordance with its provisions.
- A-2132—To provide under the Air Pollution Control Act that noise shall be considered an air contaminant and at a level greater than 108 perceived noise decibels shall be prima facie evidence of air pollution. *APPROVED*
- A-2135—To permit freeholders in a county which has no county home or hospital for children afflicted with sickle cell anemia to appropriate not more than \$5,000 each year for diagnosis and treatment of such children provided freeholders in a first class county with population over 800,000 may appropriate not more than \$10,000 each year. *APPROVED*
- A-2165—Concerning pensions of police and firemen, to define a traumatic event as applicable to any personal injury by accident arising out of and in the course of employment without regard to negligence of the employee except in cases of willtuly self-inflicted injury or intoxication is the proximate cause of injury and the test shall be whether the actual work effort contributed materially to the disability sustained. *NO ACTION*
- A-2181—To provide for the "Noise Control Act" and to empower the Department of Environmental Protection to promulgate codes and regulations. *APPROVED*
- AJR-2002—To declare March 7-13 as "Save Your Vision Week." *APPROVED*
- ACR-2005—To amend the New Jersey Constitution, after referendum, to provide that all proceeds from the State Lottery shall go to aid for education instead of for State institutions. *DISAPPROVED*, because this bill would divert revenues from the State Lottery presently earmarked for both mental health and educational programs solely to the field of education.
- AR-20—To direct the Department of Environmental Protection to conduct a study of the effects of steam emission into the atmosphere upon the ecology and environment of the State and to formulate appropriate regulations. *NO ACTION*

Of the foregoing bills . . .

(A) Eleven (11) that were *APPROVED* were signed into law: S-821, A-960, A-1056, A-1059, A-1061, A-1062, A-1063, A-1184, A-1207, A-1219, and A-1252.

(B) One (1) bill that was *ACTIVELY OPPOSED* was signed into law—S-2015.

(C) One (1) bill that was *APPROVED* lost in the Assembly—A-988.

N.B. No bills that were *DISAPPROVED* were, so far, signed into law.

FEDERAL LEGISLATION

The 91st Congress saw the introduction of several thousand bills dealing with Health Care. Significantly H.R.17550—the proposed Social Security Amendments of 1970, and the more than 10 National Health Insurance proposals all failed to gain Congressional approval. Thus these matters are all subject for consideration by the 92nd Congress.

The Social Security Amendments of 1971 have been introduced by Representative Wilbur Mills of Arkansas and received the designation of H.R.1. This bill is currently in Committee and subject to revision.

There are once again numerous proposals for national health insurance, ranging from the AFL-CIO offering to the AMA Mediredit concept. Indications are that there will be at least 15-20 bills dealing with that subject in the 92nd Congress.

Other bills of interest are concerned with the establishment and operation of Health Maintenance Organizations. Chief proposals in this regard initiate with the Administration and the American Hospital Association. Senate 892 proposes a mechanism to determine the proficiency of individuals to perform health care services payable under Medicare and Medicaid.

The text of this apparently far-reaching bill is not yet available for distribution, but should prove of prime interest to the medical profession.

Approved (page Tr 137)

Supplemental Report #1

At its meeting on 18 April, the Board of Trustees considered and acted upon recommendations from the Council's meeting of 15 April. The Council therefore offers this Supplemental Report covering items dealt with since the compilation of its annual report.

CURRENT STATE LEGISLATION

The following list presents the official position of MSNJ regarding additional bills currently in the Legislature and those bills that have been signed into law since the compilation of its annual report.

Of the bills listed in the annual report . . .

a. Four (4) bills that were *APPROVED* were signed into law: S-896, S-949, S-977, S-2140, and A-694

b. Two (2) bills that were *DISAPPROVED* were signed into law:

S-2083 —To permit licensing of graduates of foreign medical schools to practice medicine in the United States after one year of internship in a hospital.

A-2131 —To provide that no hospital which received funds under the Medical Assistance and Health Services Act shall require as a condition to serving an internship to take an examination other than that required by the State Board of Medical Examiners.

Bills currently in the Legislature . . .

S-636 —To provide that the State Sanitary Code shall not contain any regulation which requires or directs the mandatory fluoridation of any public potable water supply. *DISAPPROVED*, because MSNJ has taken a position in favor of the mandatory fluoridation of public potable water supplies. (Board-18 April 1971)

S-2111 —To provide that no dog brought to a pound or shelter shall be sold or otherwise be made available for experimentation. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

S-2120 To provide that the Board of Nursing shall consist of 5 members, 4 of whom shall be registered professional nurses and 1 a licensed practical nurse; to provide for a term of 5 years and to provide that appointments shall be made by the Governor from non-binding recommendations of various nurses' professional associations. *APPROVED*

S-2128 —To authorize the Commissioner of Health to contract with voluntary, non-profit hospitals for early care, treatment, rehabilitation, counseling, and education of drug users and their families and to appropriate \$150,000. *APPROVED*

S-2129 —To establish in the Department of Health a Health Hazard Abatement Fund where municipalities may make application to the Commissioner for funds to defray expenses incurred in abating conditions harmful to the health and safety of occupants of buildings and structures regulated by such municipalities. *NO ACTION*

S-2131 —To include under the Flammable Fabrics Act all bedding and toys. *APPROVED*

S-2135 —To permit the Commissioner of Education to send handicapped children to private operated non-profit day classes more than 400 miles from Trenton. *APPROVED*

S-2140 —To provide that "educational facility" under the Educational Facilities Authority Law shall include a teaching hospital. *APPROVED*

S-2181 —To declare the need for comprehensive control of child care centers and to establish a Child Care Commission. *APPROVED*

S-2184 —To authorize the establishment of county special services school districts for the education and treatment of handicapped children under rules and regulations to be prescribed by the State Board of Education. *APPROVED*

A-2073 —To require issuance of a medical license to practice medicine and surgery to persons achieving a 75% average in examinations given by the Medical Examining Board. *DISAPPROVED*, in support of the position taken by the State Board of Medical Examiners on the basis of their long experience.

A-2189 —To prohibit any person, who operates a corporation or business enterprise extending credit, lending money, or collecting debts from contacting personally or by telephone the debtor, his family, friends, or place of employment for the purpose of collecting any delinquent debts owed by the debtor. *DISAPPROVED*, because the bill does not make provision to except the primary extender of credit so that he may make direct contact by telephone with the debtor. (Bill withdrawn by sponsor)

A-2210 —To provide that no person shall purchase, obtain, or procure narcotic drugs outside a 20 mile limit of his residence except upon the written recommendation of his employer or a physician. *DISAPPROVED WITH ACTIVE OPPOSITION IF BILL MOVES*, because the means provided in this measure are extravagantly disproportionate to the very limited advantages that might possibly result.

A-2244 —To provide that it shall be a disorderly person's violation for anyone to abandon any disposable or reusable hypodermic needle or syringe without first destroying it. *DISAPPROVED*, because although the intent of the legislation is laudable, the measure imposes a

disproportionate burden upon patients and physicians alike in the probably vain hope of limiting and measurably restricting the activities of illegal users of drugs.

A-2246 —To require the furnishing of drinking water and toilet facilities to seasonal farm workers while working in the fields. *APPROVED*

A-2261 —To provide that no doctor of chiropractic shall directly or indirectly publish any advertisement concerning the practice of chiropractic. *APPROVED*

A-2290 —To create a commission to study the rising cost of medical care and its effect upon medical insurance. *APPROVED*

A-2294 —To require disclosure of information relative to activities of persons who seek to influence the content, introduction, passage or defeat of legislation. *NO ACTION*

A-2305 —To prohibit podiatrists, doctors of medicine and surgery, chiropractors and psychologists from engaging in any form of advertising, whether as individuals or through professional service corporations. *ACTION DEFERRED*, pending a conference with the sponsors of the measure in order to effect constructive amendments in the public interest.

A-2322 —To provide for the licensing of maternity homes by the Department of Institutions and Agencies. *APPROVED*

A-2331 —To provide that the Commissioners of Environmental Protection shall formulate and promulgate rules and regulations concerning the labeling and prohibiting, conditioning and controlling the sale of cleaning agents whose use may tend to cause adverse effects on man or the environment. *APPROVED*

A-2368 —To provide for a license fee and annual registration of persons licensed to practice medicine and surgery and to increase fees for members of various professions regulated by the State Board of Medical Examiners. *APPROVED*

A-2370 —To provide for a \$25 fee for a certificate of approval of health facilities and a \$75 fee for each inspection and approval of a public medical care facility. *DISAPPROVED*, because this measure would impose an added economic burden on the taxpayers for carrying out a procedure for which taxes have already been collected.

Approved (page Tr 137)

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Supplemental Report #2

CURRENT STATE LEGISLATION

Since the preparation of the first supplemental report on legislation for presentation to the House of Delegates, the Governor has signed into law the following four bills concerning which the Society has taken an official position:

S-2088—To provide for a Health Care Administration Board in the Department of Health with the Commissioners of Health and Insurance as ex-officio members, to authorize the Commissioner of Health to inquire into the operation and conduct inspections of medical care facilities, to adopt regulations, to provide for licensing and to transfer all functions related to administration of laws concerning boarding homes for sheltered care, care of children and adults, private mental hospitals, convalescent homes, private nursing homes and private hospitals from the Department of Institutions and Agencies to the Department of Health. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES*, because it poses a threat to the free practice of medicine, concentrates excessive power in the hands of one person, and jeopardizes the continuance of the life and operation of the Medical-Surgical Plan of New Jersey (New Jersey Blue Shield).

In a series of conferences culminating in a public hearing on S-2088 held on 23 March

the Society's opposition was thoroughly set forth. Subsequently S-2088 was amended in Senate Committee and the new version effected amendments that overcame the Society's opposition to the concentration of excessive power in the hands of one person by requiring that the Commissioner formulate and promulgate rules and regulations only with the approval of the Health Care Administration Board, which was enlarged to have a total of thirteen members. On the basis of the fact that thus the chief objection of the Society to S-2088 was overcome, from that point on the Society did not continue to oppose S-2088. S-2088 specifically excludes services provided by a physician in his private practice from the health care services that fall within the purview of this legislation.

A-1211—To establish a state-wide system of Drug Abuse Treatment and Counseling Clinics under the direction of the Commissioner of Health. *APPROVED*

A-2001—To permit blind persons with trained seeing-eye dog guides to enter into all public places. *APPROVED*

A-2056—To delete the requirement that the county medical examiner shall be a resident of the county in which appointed. *APPROVED*

Approved (page Tr 137)



Fellows, l to r: Collins, Jehl, Bedrick, McCall, Kustrup, Kaufman, Calvin.

Administrative Council

Medical Services

Louis K. Collins, M.D., Chairman, Glassboro

(Reference Committee "F")

The 1970-1971 Administrative Year proved to be an active and eventful one, as the following detailed report will reveal.

REPEAL OF ANTISUBSTITUTION LAWS

Various states faced the problem of combating legislation that would repeal their respective antisubstitution statutes. The Board of Trustees, through the urging of this Council, adopted a position in support of the AMA to resist vigorously any attempts at repeal of our New Jersey Antisubstitution Statute. The position of the Society was made known to the New Jersey Pharmaceutical Association. Thus far, we are happy to report, no bill has been introduced in New Jersey that would alter the current Antisubstitution Statute.

Approved (page Tr 140)

BENNETT AMENDMENT—MEDICARE—MEDICAID

The Council urged the Board of Trustees to go on record in support of the AMA's position of opposition to the Bennett Amendment relevant to Medicare and Medicaid. The Board of Trustees concurred. The Bennett Amendment failed to pass the December 1970 session of Congress.

Approved (page Tr 140)

FEE INEQUITIES UNDER MEDICARE AND MEDICAID

The inherently inequitable circumstance whereby an experienced practitioner is locked into an unduly low fee profile while the practitioner newly entering medicine today has the chance to establish a more reasonable basis of compensation was discussed at length with the fiscal intermediary. We

have heard that there is a correct mechanism which, although not ideal, at least offers some relief. The physician in question must submit his complaint in writing to the carrier and evidence at least a six month billing pattern at the new rate in order to justify his request for an adjusted fee profile.

The fiscal intermediary, of course, can act only in accordance with Federal law and regulations. As long as the program is on the basis of usual and customary fees, there will be an inevitable time lag between the adjustment of fee levels and recognition by the intermediaries and HEW.

Approved (page Tr 140)

FORMATION, FUNCTIONING, AND RESPONSIBILITIES OF UTILIZATION REVIEW COMMITTEES

At the request of the Board of Trustees the Council drafted guidelines for utilization review committees. As all members of the Society can well imagine, the recent emphasis on peer review made our deliberations both controversial and complicated. We considered two or three drafts, all of which were subject to major review and alteration by the Council members. Finally, at our February meeting, the Council unanimously adopted the following guidelines which the Board of Trustees approved at their March meeting.

Peer review as applied to the profession of medicine means that all investigation and evaluation of the services and activities of physicians are made by other physicians. This term is generic. There are many facets of medicine open to peer review; Credentials Committees and Tissue Committees are but two examples. Utilization review is another, as is the quality of care provided. These latter two aspects are of great current interest because of third party payer concern.

Preamble: There seems to be some misunderstanding and possible disagreement concerning the above title. Some persons and some medical societies have Utilization Committees (serving in hospitals) and also Review Committees at county medical or state society

level, which go beyond utilization and actually resemble our State Society Judicial Mechanism to some extent in that they consider fee disputes which they arbitrate. In New Jersey we believe that a proper mechanism exists in our *Judicial Committee* to adjudicate and arbitrate, and respond to patient, doctor, hospital, and third party payer complaints.

We shall consider hospital based and county medical society formed Utilization Review Committees as essentially the same. Their formation would be different as elected or appointed by hospital staff or county medical society, but their operation similar.

The Utilization Review Committee should be concerned not only with Medicare, Medicaid, and other third party paid patients, but with all occupants of hospital and Extended Care Facility beds. The Utilization Review Committee should devote particular attention to:

1. Unnecessary admissions
2. Excessive length of in-patient stay
3. Delay in use or over-use of x-ray, laboratory, and other diagnostic and therapeutic services
4. Delay in consultation or referral

In addition, the Committee should study patterns of care, i.e., studies ordered, treatment rendered, frequency of complications, length of stay of particular category compared to AID or PAS.

The Utilization Review Committee should have no enforcement or punitive powers of its own; it should be advisory and educational to all parties concerned.

The Utilization Review Committee should work closely with Medical Records Committee, the Tissue Committee, and OR, Admissions, Pharmacy, and other medical staff committees. Thought should be considered to including the functions of medical audit, tissue review, and infection control committees into the Utilization Review Committee.

The Utilization Review Committee should conduct an on-going current review of charts, not only a study of discharged patient's charts.

The Utilization Review Committee should make recommendations to appropriate medical staff committees, chiefs of services, or administration regarding the following:

Administration:

1. Institute methods to overcome delays in transmitting orders and carrying out various diagnostic and therapeutic procedures
2. Overcome inadequate weekend and night coverage of facilities
3. Strengthen Social Service
4. Integrate admission schedule and OR schedule
5. Increase the availability of ambulatory patient service.

Chief of Service:

1. Analysis of cases indicating delay or neglect in obtaining consultation
2. Analysis of wide variations in length of stay of cases with same diagnosis
3. Consideration of unnecessary hospital admissions
4. Consideration of unnecessary utilization of lab, x-ray, and other ancillary services
5. Duplication or excessive use of multiple physicians

The Utilization Review Committee should make regular reports and have regular meetings with minutes available for proper authorities; the Utilization Review Committee should develop appropriate forms and checklists in order to facilitate its operation.

The county medical society Utilization Review Committee would properly function in Extended Care Facilities and in smaller hospitals with no Utilization Review Committees of their own.

The possibility of one hospital's Utilization Review Committee working in another hospital should not be overlooked. This would not only be an enlightening experience but would forestall the Governmental approach to Peer Review.

The Utilization Review Committee should be able to prove that it actually does influence effective utilization for the better.

Approved as corrected—change "Council" to "Committee" in 3rd sentence of Preamble. (page Tr 140)

RELATIVE VALUE INDEX

We had been charged by the 1970 House of Delegates with the updating and revision of the 1964 California Relative Value Studies to suit the needs of MSNJ members.

Information received from The Medical-Surgical Plan of New Jersey and various state and specialty societies revealed that the Fifth Edition of the California Relative Value Studies (1969) is now commonly accepted. Detailed perusal of both versions indicates that the complexity of recent procedures makes it virtually impossible to amend the 1964 version so that it would be suitable for our use.

As previously noted, the 1969 version of the California Relative Value Studies is widely accepted. We have attempted to secure copies of that production for the use of the component societies. With the approval of the Board of Trustees we offer the following:

Recommendation

That The Medical Society of New Jersey adopt—as its updated version—the Fifth Edition (1969) in its most recent form, of the California Medical Association Relative Value Studies.

Approved. It was pointed out that the index should be used only as a guideline, (page Tr 140)

Certainly we can anticipate that the upcoming year will again produce a substantial amount of work for the Council's consideration. That new amendments to the Medicare and Medicaid Acts will pass the current Congress is a foregone conclusion. In those amendments we will undoubtedly see the establishment of a nationwide peer review mechanism and the establishment and operation of Health Maintenance Organizations. To keep abreast of developments in this regard, the Chairman of the Council attended a

Regional Meeting on "Peer Review" conducted by the AMA in Washington, D.C., and also an HEW sponsored program on "Health Maintenance Organizations" in New York City in the latter part of March.

I thank all the members of the Council for their diligent and dedicated efforts this past year.

Approved with notation (page Tr 140)

Special Committee to Council on Medical Services

Occupational Health, Workmen's Compensation, and Rehabilitation

Joseph A. Lepree, M.D., Chairman, Elizabeth
(Reference Committee "F")

The Committee has had no formal meetings this year and thus has no formal report to

make to the House.
No action necessary.



Immediate Past-President
Bertha, his daughter-in-law,
and granddaughters.

Administrative Council

Mental Health

Edward A. Schauer, M.D., Vice-Chairman, Farmingdale

(Reference Committee "F")

This year the Council has labored without the benefit of its original and only Chairman, Robert S. Garber, M.D. Dr. Garber was unable to attend our meetings because of the extraordinary demands upon his time in consequence of his service as President of the American Psychiatric Association this past year. We take this means formally to congratulate Dr. Garber for his achievements, particularly the reception of the Mount Airy Gold Medal for distinguished service in the field of psychiatry. His return to the Council will be welcomed by all.

The Special Committees to the Council have generated much activity during the year. The details of their deliberations appear in their respective reports. I shall confine my comments to two very sensitive and volatile areas of concern to all physicians.

SEPARATE DEPARTMENT OF MENTAL HEALTH AND RETARDATION

The 1970 House of Delegates adopted Resolution #13 as amended which called for the establishment within the State Government of a separate Department of Mental Health and Mental Retardation, with a board certified psychiatrist as Commissioner thereof.

The New Jersey Senate Committee on Institutions and Welfare contracted with the American Psychiatric Association for a survey of New Jersey Mental Health Needs and Resources. That survey was conducted over an extended period of time, and the results thereof were reported to the Senate Committee on Institutions and Welfare in February 1971. Although the report has been made public it has not, for some inexplicable reason, been widely distributed. The Council however, has reviewed it in depth and detail.

The report agrees unequivocally with Resolution #13 as adopted by the 1970 House of Delegates. We believe it is timely and proper for The Medical Society of New Jersey to reaffirm its position in this regard. Since there is some question as to what the reaction of the State Government will be in regard to the APA report, we *recommend* that the House of Delegates adopt the following position:

The 1969 House of Delegates adopted Resolution #21 which called for the Society to petition the Governor to survey and restructure New Jersey mental health programs. Subsequently, the New Jersey Senate Committee on Institutions and Welfare contracted with the American Psychiatric Association Contract Survey Board for report and recommendations relevant to the New Jersey Mental Health Program.

Anticipating that the survey would be extensive and prolonged, this Society adopted, in 1970, Resolution #13 which called for the State Government to establish as a principal agency a "Department of Mental Health and Mental Retardation with a board certified psychiatrist as Commissioner thereof." The APA Contract Survey Board submitted its final report to the Senate Committee on Institutions and Welfare in February 1971. That report calls for the establishment within the State Government as a principal agency thereof, of a separate Department of Mental Health with a board certified psychiatrist as Commissioner responsible directly to the Governor.

Recommendation

That MSNJ reaffirm its position in favor of the establishment within the State Government of a separate Department of Mental

Health, with a board certified psychiatrist in charge and responsible directly to the Governor.

Approved (page Tr 141)

The Council was pleased to learn that the President has appointed two of our members to serve on a Steering Committee formed by the New Jersey Neuro-Psychiatric Association and the New Jersey Mental Health Association and several other appropriate agencies to seek the effectuation and implementation of the APA Contract Survey Board Report.

PSYCHIATRIC SERVICES

The Council is dismayed to see that legislation has once again been introduced that would under insurance programs equate services rendered by a psychologist with those of the physician. The Society has of course dis-

approved those bills. In 1966, The Medical Society of New Jersey and the then Committee on Mental Health, vigorously opposed legislation that licensed psychologists and granted them the privilege of practicing psychotherapy. The Legislature and the Governor however, ignored our protests and the bill became law. We are still opposed to this concept.

Recommendation

That MSNJ reaffirm its opposition to the unsupervised practice of psychiatric modalities, including psychotherapy, by persons not licensed to practice medicine and surgery.

Approved (page Tr 141)

Approved. Reference Committee urged continued efforts in opposition to unsupervised practice of psychiatric modalities (page Tr 141)

Special Committees to Council on Mental Health

Alcoholism

George A. Rogers, M.D., Chairman, Camden
(Reference Committee "F")

The main concern of the Special Committee on Alcoholism in all its meetings over the year was to try to determine how The Medical Society of New Jersey could best help combat the increasing prevalence of alcoholism. Much of the work of the Committee was directed toward determining what had been done and what was being done in the State hospitals, general hospitals, and the medical schools in New Jersey in regard to the problem of alcoholism.

Our survey of what was being done and what was needed was not completed as of our last meeting, and it is hoped that this constructive inquiry can be continued by the Committee next year.

The first order of business was Resolution No. 27 from the 1970 House of Delegates, which was referred to our Committee for study. This resolution concerned the establishment of Alcoholism Detection Clinics and Alcoholism Week in each component county society. Dr. Shenkman, Bergen County, the originator of the Alcoholism Detection Clinics, was invited to, and attended, the initial meeting of the Committee. A good deal of information concerning the results of the Detection Clinics and the publicity preceding them was examined, evaluated, and discussed by the Committee. A recommendation was sent to the Mental Health Council, supporting Resolution No. 27, but this recommendation was modified by the Council.

In an effort to obtain guidance and a survey of the needs of New Jersey in the field of alcoholism, letters were written to Drs. Garber and Schauer, to Mr. Harris of the State Health Department, to Dr. Wolman of the Alcoholism Committee of the American Medical Association, and to the appropriate committee of the component county societies, as well as to Alcoholics Anonymous.

After learning of some of the difficulties in New Jersey in obtaining treatment for alcoholics, it was recommended that each State hospital have a unit devoted solely to the treatment of alcoholism. (See recommendations below).

At the suggestion of Mr. Harris of the State Department of Health, with whom the Committee met, the Medical Directors of the ten State-funded Alcoholism Clinics were invited to attend a meeting of the Committee to discuss their problems and needs. This meeting, which five Medical Directors attended, was a particularly useful and informative analysis of the status of education concerning and treatment of alcoholism in New Jersey. The Committee was able particularly to get a view of the status of education on alcoholism at the College of Medicine and Dentistry of New Jersey at Newark from the presentation by Dr. Francis Smith of the College and Martland Medical Center.

The Committee recommended to the Council that improvement be made in the teaching curricula in regard to alcoholism in the State medical schools, particularly with regard to teaching the treatment of chronic alcoholism, and to teaching it as a total rehabilitative process, rather than as a strictly medical problem. A recommendation was also made that teaching in the State's general hospitals in regard to treatment of alcoholism be supported by State funds, and that the Academy of Medicine conduct an educational program on the treatment of alcoholism.

A guide for the treatment of the acute alcoholic, prepared and submitted by Dr. Paul

Fagan of Mountainside Hospital, was considered, and its dissemination was recommended.

The following *recommendations* were approved by The Council on Mental Health and by the Board of Trustees:

1. That each component medical society be urged to stimulate the development of facilities for the detection and treatment of alcoholism and related conditions, in cooperation with all medical and social organizations that can assist in such a program; that the county societies and the detection and treatment facilities be urged to effect close liaison between practicing physicians and these facilities; and that The Medical Society of New Jersey recommend that each of these presently existing alcoholism facilities, as well as those established in the future, be placed under the supervision of a physician fully licensed by the State of New Jersey.

2. That The Medical Society of New Jersey use all of its influence to have incorporated in the curricula of the appropriate departments of the medical schools (medicine and psychiatry) a more adequate program devoted to the subject of alcoholism, and more specifically the treatment of the alcoholic.

3. That MSNJ urge the directors of medical education to include treatment of alcoholism and the acute alcoholic in the appropriate approved residency programs.

4. That the Board of Trustees of The Medical Society of New Jersey, cognizant of the epidemic proportions of alcoholism, urge the State to make funds available to general hospitals to be utilized in post-graduate education programs for physicians, in combating this chronic disease.

5. That the Board of Trustees of The Medical Society of New Jersey urge the Academy of Medicine to conduct educational programs for the practicing physician on the treatment of alcoholism.

6. That the outline, "The Practical Management of the Acute Alcoholic" be referred to the Editor of *The Journal*, to be used at his discretion, with the approval of its author, Paul C. Fagan M.D., as an informational item in *The Journal*.

Unfinished business, which it is hoped the Committee will take up next year, consists of contacting Mr. James Deans, Executive Director of the New Jersey Alcoholism Council, for his thoughts on New Jersey's needs, con-

tacting a representative of the Alcoholics Anonymous groups of New Jersey, for their thoughts about the needs of New Jersey, and holding interviews with Mr. Nicholas Heil, Governor Cahill's representative, and Dr. Wolman from the AMA, in regard to the implementation of the recently passed federal legislation concerning support for the community treatment of alcoholism.

Approved with notation (page Tr 141)

Drug Abuse

Henry A. Davidson, M.D., Chairman, East Orange

(Reference Committee "F")

The wretched problem of drug abuse continues to haunt our culture. We physicians do not seem any more skillful in meeting the problem than the social workers, clergymen, school teachers, psychologists, penologists, pharmacologists, and other assorted well-meaning people have been. Some of us take refuge in the fact that the physician's job is to detoxify and say that once we do so, the problem of preventing a relapse belongs to workers in the other behavior science fields.

While this is something of a cop-out, it is true that we in medicine don't really know much about the factors that cause an addict to return to the pill, the vapor bag, the snort, or the needle. From one point of view, people turn to drugs when their life style is otherwise unsatisfactory. Therefore to attack the problem basically, we must change the life style . . . hardly the physician's job. From another point of view, those who depend for their satisfaction on "things" rather than on human beings, fall back on things—including drugs—when they are troubled. Or it may be that drug abuse is a kind of fashion, or even a contagious spread, as the word implies, by contact with others. Many of the abusers to-

day are from comfortable middle-class homes, so that we can no longer console ourselves with the thought that this is only a ghetto problem or the by-product of poverty.

All of this has left our profession in a spirit of hopelessness. Into the vacuum thus created, other professional and self-help groups have eagerly moved. The one most dramatic development in the past year has been the burgeoning of the methadone program. Since methadone has to be prescribed by physicians, it remains the one method that is essentially within our control. It also meets the need we all have to do something specific about the matter. The other prescriptions, concerning emotional and sociologic parameters, are too vague and abstract to offer any practical assistance.

So far the verdict on methadone is mixed. Some object that it is not proper to fight addiction to one drug by inducing addiction to another. Some object that it opens the door to a black market in methadone. Others fear that the priming effect of methadone on a person taking heroin will make him even more addicted. In spite of those objections,

we have so little to offer that we cannot turn down anything that might help; and certainly methadone is in this category.

At present there is controversy about the possibility of outpatient induction of (or maintenance by) methadone. The State Methadone Maintenance Program has worked out an outpatient regime which sets up all kinds of safeguards and which, we feel, is worth trying.

In December 1969 the state osteopathic association asked if they could send observers to our meetings and we agreed. So far, however, none has appeared. We have also been in touch with the state pharmaceutical association and with the Division of Drug Abuse at the College of Medicine and Dentistry of New Jersey in Newark.

There has been some criticism of the extensive efforts being directed at heroin addicts with a relative slighting of those who have become habituated to amphetamine, marijuana, barbiturates, and L.S.D. People worried about alcoholism have also complained that alcohol addiction is, perhaps, ten or even twenty times as common as drug addiction, yet gets much less share of public and professional attention, energy, time, and money.

The Journal has been most helpful in accepting several articles on the subject and in publishing the column "Behind the Drug Scene." The column and articles have provided a useful channel between those who work intimately on the problem and the medical profession in general.

Approved with notation (page Tr 141)

Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., Chairman, Paramus
(Reference Committee "F")

The focus of the Committee's work this year was its interest in special educational facilities for mentally ill children and adolescents. Several meetings were held with officials of the Bureau of Special Education and Pupil Personnel Services of the Department of Education. These meetings served to clarify problems and procedures in providing services for these ill youngsters, and to promote coordination between educational and medical and psychiatric services for them. As an outgrowth of this, the Bureau and the Committee jointly prepared an informational exhibit for

the 1971 MSNJ Annual Meeting. This exhibit is aimed at informing the physicians of the state of appropriate procedures to be used in entering and maintaining youngsters in the special educational "system", and of what channels are available for corrective action should the "system" not be serving the needs of a particular patient. The Committee also made plans for continuing programs better to inform physicians and associated mental health professionals in these matters.

Approved with notation (page Tr 141)



Head Table—Dinner Dance.

Mental Retardation

Miles E. Drake, M.D., Chairman, Vineland

(Reference Committee "F")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.
No action necessary

Seizures

J. Lloyd Morrow, M.D., Chairman, Passaic

(Reference Committee "F")

The Special Committee on Seizures met on two occasions with the Executive Assistant and invited guests.

The Committee was especially gratified by the successful culmination of years of effort in the passage of revised Legislation on convulsive disorders entitled, "An Act, concerning reporting of epilepsy and repealing Sections 26:5-1 through 26:5-13 of the Revised Statutes," which was signed by the Acting Governor in September 1970 (Senate Bill 573). This Act is the subject of an Exhibit at this Annual Meeting which explains the functioning and the intent of the revised legislation.

The Committee studied and classified seizure disorders and their treatment and evolved a pocket-sized card entitled, "Epilepsy Treatment Guide." At its 1970 Annual Meeting the House of Delegates approved the pocket card and recommended that an enlarged version of it be made available to every hospital for display in the emergency rooms. Accordingly, a total of 93 New Jersey General Hospitals received a large poster-size version of the Epilepsy Treatment Guide and 8,265 pocket-sized cards were sent to the component medical societies for distribution to their members.

function of the Committee in view of its work in implementing the mandates originally imposed upon it; namely, seizure delimitation, education, legal implications, liaison, and collaboration. It was felt that those mandates which were not completed and which were of an ongoing nature were not only seizure disorder in character but of a more general category better subserved by the broader orientation of neurology. Attention was called to the relative lack of significant identification of neurology to its appropriate degree of importance in the Mental Health Council. It was therefore recommended that the Council on Mental Health move to change the name of this Committee to the "Special Committee on Neurological and Related Disorders," which recommendation was subsequently approved by the Council on Mental Health and by the Board of Trustees.

In conformity with our educational and therapeutic objectives, the Committee met with Mr. James F. White, President, New Jersey Chapter, Epilepsy Foundation of America, to discuss the program of that organization and the possibility of our cooperation in service to the people of our state. Further study will be required for completion and implementation of this project.

Much discussion was devoted to the valid
Approved (page Tr 141)

Administrative Council

Public Health

Robert G. Salasin, M.D., Chairman, North Wildwood

(Reference Committee "G")

Most of the matters coming before the Council have their origin in the Special Committees. Our report, therefore, deals only with matters particular to the Council. The detailed reports of the Special Committees will follow this report.

ADMISSION OF TUBERCULOSIS PATIENTS IN GENERAL HOSPITAL

The Board of Trustees referred to the Council a communication from the Tuberculosis-Respiratory Disease Association of New Jersey wherein MSNJ's endorsement of a policy statement was requested. That statement reads as follows:

Recently the need has arisen in some areas to treat tuberculosis patients in general hospitals either because specialized tuberculosis hospitals are not available or other urgent medical (non-tuberculosis) problems necessitate it. New Jersey has a state hospital, the New Jersey Hospital for Chest Diseases at Glen Gardner, which cares for patients with any respiratory disease requiring prolonged convalescence. There are also several county institutions which accept tuberculosis patients.

There may be instances, however, when medical or social reasons may dictate consideration of the short-term admission of a tuberculosis patient to a general hospital:

- (1) Serious accident or acute illness requiring emergency treatment which cannot be provided by the state or county chest hospital.
- (2) The need for diagnostic studies and interim treatment while long-term plans for care are being made.

When any of these situations suggest the short-term admission of TB patients to a general hospital, the hospital, with planning, can manage the tuberculosis easily and safely, based on today's concepts of treatment and transmission of this disease.

During recent years, scientific studies have shown that TB patients—even those with advanced disease—can be treated very well in a general hospital because the patient becomes rapidly noninfectious after the initiation of chemotherapy and because simple precautionary measures can be used to stop the spread of tubercle bacilli during the usually brief time he is infectious following admission.

The Council recommended that The Medical Society of New Jersey endorse in principle the foregoing statement and the Board of Trustees concurred. In addition, the Council further recommended that The Medical Society of New Jersey register concern that the recalcitrant patient loads might, with the phasing out of county residential facilities, create an excessive demand on the remaining state facility. The Board of Trustees did not agree and tabled that further recommendation because there was no documentation that an excessive burden would be placed on Glen Gardner.

PROCTOSIGMOIDOSCOPY EXAMINATIONS

It was brought to the attention of the Council that in certain instances the fiscal intermediaries under Medicare and Medicaid have refused to recognize the validity of a claim for a proctosigmoidoscopy examination. The Council recommended that the Board of Trustees advise the fiscal intermediaries that such a procedure is indicated for patients over 40 years of age and should not be categorically dismissed as "not medically indicated." The Board of Trustees, in considering this matter, amended the recommendation by deleting the reference entirely to "patients over 40 years of age" and added the thought that the procedure is indicated when "related to the complaint." The fiscal intermediary has been so informed.

AUSTRALIA ANTIGEN SCREENING OF BLOOD UNITS

The Council was informed of a letter sent to Blood Bank Directors from Martin Goldfield, M.D., Director, Division of Laboratories,

New Jersey State Department of Health, concerning "Australia Antigen Screening of Blood Units, dated 5 August 1970. The letter states ". . . Should it be necessary to use untested units for the preparation of fresh components, it is suggested that pints taken for such processing be chosen from donors who have contributed other units during the previous year that had been tested and reported to you as being Australia antigen negative." Certain hospital personnel have interpreted the letter to mean that only tested blood may be transfused. The Council did not agree and did not believe this was the intent of Dr. Goldfield; therefore it *recommended*:

That a letter be sent to Dr. Goldfield explaining what has happened and requesting that he clarify his previous letter insofar as there is a definite need for fresh blood in acute and surgical bleeding cases, and that it may be transfused without the implication that the physician is not practicing good medicine.

The foregoing was approved by the Board of Trustees and the appropriate communication sent. At our January meeting we noted that the Department of Health had not yet replied. We therefore urged the Board to send a follow-up letter. Subsequent to our meeting, a letter of explanation was received. Although the clarification given was satisfactory the Board noted that it was not distributed to the Blood Banks and has, therefore, requested Dr. Goldfield to send the letter to all Blood Bank Directors who received the original 5 August 1970 statement.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

The Council discussed the evaluation of hospitals for accreditation by the Joint Commission. It was our opinion that in addition to the present practice of examining the hospital records and the physical plant, nursing care and the quality of care rendered in the institution should be a part of the inspection. We recommended to the Board that the Joint Commission be urged to conduct a confidential survey of staff physicians prior to inspection to obtain their opinion as to the quality

of care in the hospital. The Board felt that the present method was satisfactory and therefore disapproved our recommendation.

FDA PRONOUNCEMENT CONCERNING THE USE OF ANTI-DIABETIC MEDICATIONS

The Council fears that the announcement by the FDA concerning the efficacy and side effects of certain anti-diabetic medications and other announcements in a similar vein may tend to jeopardize the physician-patient relationship and the confidence necessary thereto.

The following report was offered to the Board of Trustees.

The Council on Public Health has received a letter from the New Jersey Public Health Association through its President, Dr. Oscar Sussman, dealing with the controversial University Group Diabetes Program Study on the treatment of diabetes. This communication dealt with the unfortunate release of interpretations of parts of the data to the public media before physicians had any information, and the subsequent precipitate actions of the Food and Drug Administration, both of which caused unnecessary alarm and confusion among a million diabetic patients and a loss of confidence in their physicians and program of therapy.

Inadequate statements by the American Medical Association and the American Diabetes Association have not clarified the issues. New Jersey physicians who treat patients with diabetes are forced to practice defensively under the threat of lawsuit as a result of this situation. After careful deliberation on the issues, this Council suggested that the Board of Trustees consider the following:

1. The University Group Diabetes Program Study, which cost \$7,000,000 and almost ten years of work, had many good features. However, experts question the validity of the interpretation of the data because of deficiencies in homogeneity in baseline cardiac risk factors; the techniques of statistical analysis, the arbitrary and atypical mode of treatment of patients, the sweeping extrapolation of the results to the whole universe of diabetic patients, and the condemnation of the whole spectrum of oral hypoglycemic drugs, despite the fact that only tolbutamide, and, for a shorter period, phenformin were studied.

2. The uncritical and premature recommendations of the Food and Drug Administration on the treatment of diabetes in the Food and Drug Administration Current Drug Information letter (October 1970) to physicians are confusing, impractical, and a disservice.

3. The Food and Drug Administration was overbearing and short-sighted in requiring a change of package insert by manufacturers of oral hypoglycemic drugs, despite the request to the contrary of an important group of diabetes specialists.

4. Releases by the public media (press, radio, and T.V.) were out of context, and frightening, placing physicians in an embarrassing and compromising position when they had no printed scientific material to read on the subject.

5. The poor judgment and ill-conceived actions described above have shaken the foundation of good medical and public health practice in the control of this chronic metabolic disorder, and have resulted in a danger to the conception and completion of clinic research itself in the future.

6. Finally, this unwise interference with the physician's care of his patient by a governmental regulatory agency represents the practice of medicine "by fiat," while the physician has no protection from unjustified legal action.

The Council on Public Health recommended the following:

That the Board of Trustees consider this matter promptly, and issue a protest to the Food and Drug Administration.

The Board of Trustees approved of this statement at its 21 March 1971 meeting.

Approved (page Tr 143)

Special Committees to Council on Public Health

Cancer Control

John L. Olpp, M.D., Chairman, Englewood

(Reference Committee "G")

The application for space at MSNJ's Annual Meeting to further education of physicians in proctosigmoidoscopy was withheld because adequate supervision of the instruments and manikins could not be assured.

The Committee suggests that proctosigmoidoscopy and "Pap" Tests be "routine" for all new patients over 30.

The manuscript entitled "A New Approach to Treatment of Inoperable Malignancies" was received and discussed. Publication in *The Journal* was not recommended in view of the paucity of cases of proved malignancy and the short follow-up period.

Tumor Registries are very helpful in determining the results of cancer therapy in community hospitals. A Workshop for Tumor Registry Secretaries and Tumor Activity Chairman is planned for June 1971. It will be

co-sponsored by the New Jersey Regional Medical Program, American College of Surgeons, and the American Cancer Society.

The Committee recommends approval of this workshop by The Medical Society of New Jersey.

It is also recommended that the hospitals of the State of New Jersey be surveyed to determine the number and location of functioning tumor registries. The survey will include all hospitals of over 100 beds. The published reports by the American College of Surgeons will be included in the survey.

Approved. Reference Committee felt that the statement suggesting that proctosigmoidoscopic and pap tests be routine for new patients over 30 should be dealt with in greater detail (page Tr 144)

Child Health

William J. Farley, M.D., Chairman, Nutley

(Reference Committee "G")

PERINATAL STUDY CONFERENCE PROGRAM

A suggested Guide for the Hospital Perinatal Study Conference, formulated jointly with the Committee on Maternal and Infant Welfare, and approved by the Board of Trustees, has been sent to the Hospital Administrators, Directors of Medical Education, and Chiefs of Obstetrics, Pediatrics, and Pathology in 83 hospitals in New Jersey. The Guide has also received the endorsement of the New Jersey Obstetrical and Gynecological Society, the New Jersey Chapter of the American Academy of Pediatrics, and the New Jersey Academy of General Practice. The cooperation of each of the component county societies was also requested to promote the utilization of the Guide in the hospitals within their counties.

The purpose of this statewide program is to encourage regular study conferences through a simple and practical format. The periodic self-evaluation and review of each individual hospital by its own staff represents an effective instrument to meet the formidable challenge of perinatal morbidity and mortality. Its primary function is educational, however, effective measures to improve the quality of management of mother and newborn infant may also be anticipated and initiated through acceptable recommendations of its study conferences.

SCHOOL HEALTH

The following recommendations were approved by the Board of Trustees:

1. That MSNJ record itself as urging that all school physicians accept responsibility and leadership by becoming actively involved in the administration of school health services in their respective communities, thereby promoting maximum health services for all school children in the State of New Jersey.

2. That MSNJ direct an appeal to the Governor, as well as to Commissioner Marburger of the State Department of Education, requesting the creation of an Advisory Council on School Health, which shall be composed of qualified physicians and health professionals, such as nurses, educators—particularly in health and physical education—and other interested persons, including parents, to assist the office of Health, Safety, and Physical Education to explore, develop, and service all areas of school health.

3. That management of learning disabilities should include medical participation in the Child Study Team.

A letter to Doctor Marburger, Commissioner, New Jersey Department of Education, requested that a practicing physician be a full and regular participating member of each Child Study Team and not simply an ancillary consultant.

DELIVERY OF HEALTH CARE UNDER MEDICAID

Members of this Committee have jointly participated in recent meetings of the Advisory Committee on Child Health of the Medicaid program. Of particular concern has been the problem of claims for newborn services, since it represents an essential area of care.

The Committee has also stressed the need for adequate study of the utilization of services and the implementation of the necessary systems for delivery of care.

FLUORIDATION OF PUBLIC WATER SUPPLIES

Following extensive review, the Committee is of the opinion that the Society's position is contradictory. The House of Delegates in 1952 and in 1960 adopted a position in favor of fluoridation, but in 1970 approved Senate Bill #636 that prohibited the only practicable means for its accomplishment, that of mandatory fluoridation. In consequence, the Committee voted to recommend:

Recommendation

That the Board of Trustees officially change the position of the Society on S-636 from approval to disapproval in order to make the Society's position on fluoridation consistent throughout. And it further *recommends* that MSNJ formally adopt as its official position

the mandatory fluoridation of all public potable water supplies on a statewide basis under regulations promulgated by the State Department of Health as the only feasible method to accomplish fluoridation of public water supplies in New Jersey.

Approved (page Tr 144)

Conservation of Vision, Hearing, and Speech

Frank B. Vanderbeek, M.D., Chairman, Paterson

(Reference Committee "G")

The Committee on the Conservation of Vision, Hearing, and Speech met on 22 November 1970. At that time, the results of the Eye Health Screening Program conducted in September—with Dr. Cinotti as Chairman—were reviewed.

There were 85 participating centers (an increase of two over the previous year). The total number screened was 10,986, as compared with 11,114 in 1969. The total number of negative results was 5,039 and of positive results 4,901. There were 456 tonometry suspects. (There were 464 in 1969.)

As indicated, the results of this survey were comparable with those of the previous year. A slight decrease in the number screened and of positive findings were recorded.

The Committee noted the decrease in the number screened. It agreed that more publicity for the program was needed at the local level and suggested that the key man at each hospital contact the hospital's Public Relations Office to improve the advance publicity in future surveys.

The Committee also directed that at the beginning of next year's program, a letter be sent to the New Jersey Hospital Association asking for full cooperation.

In their reports, physicians in charge of this program had been asked for suggestions to improve the survey. These suggestions were discussed at length. As a result of these discussions, it was recommended that the name be changed from "Eye Health Screening Program" to "Glaucoma Detection Week"; and that the recommended tests with and without glasses and tonometric determinations be made of each patient. The Committee vote on the recommendation was divided: five for and four against.

Subsequently, Doctors Cinotti and Diskan sent minority opinions to be presented to the Council on Public Health. Dr. Skowron, absent from the meeting, also sent a letter deploring the actions taken by the Committee. Mr. Joseph Kohn, Executive Director of the New Jersey Commission for the Blind (a co-operating agency) also sent a letter deploring this action. Dr. Siegel also sent a letter to the Council on Public Health giving, in detail, the reasons held by those approving the action.

The Council on Public Health, noting the essentially even vote, requested the Committee to meet again after polling the ophthalmologists in the state, to reconsider the action. The Society was requested to obtain the mailing list of the New Jersey Academy of

Ophthalmology and Otolaryngology and send such questionnaire.

The Board of Trustees disapproved the Council's recommendation and directed that the present name and purpose of the Eye Health Screening Program be retained. The Board approved an Eye Health Screening Program to be conducted in September 1971.

The Committee also recommended that the Board of Trustees send a follow up letter to Attorney General Kugler asking for an official opinion concerning the use of a local anesthetic by an optometrist performing a corneal tonometric examination. He replied that he was not authorized to reply to this request—such a request must originate from a state board. The State Board of Medical Examiners has been requested to place this question to the Attorney General.

The Committee also recommended that the Board of Trustees write the State Board of Medical Examiners inquiring as to how optometrists may legally obtain drugs since they are not licensed to prescribe or dispense them. No reply has as yet been received.

The Committee further voted to recommend to the Board that a letter be sent to the New Jersey Board of Pharmacy apprising them of the fact some pharmacists may be filling prescriptions for anesthetic drugs on the prescription of optometrists, and requesting an opinion as to the legality of such a procedure. No reply has yet been received.

The Committee also requested The Medical Society of New Jersey to pay the expenses for a display on "Dyslexia" at the Annual Meeting, with Dr. Diskan in charge of this exhibit. The Committee also recommended that an exhibit on Dyslexia be financed by The Medical Society of New Jersey to be exhibited at the New Jersey Education Association's Convention in 1971. This was approved by the Board, with the stipulation that these expenses do not exceed \$200.00.

The Committee further recommended that in view of the increased problem of Dyslexia, the policy statement on Dyslexia be reissued to all school nurses and school personnel to encourage proper treatment of this disorder.

Approved (page Tr 144)

Environmental Health

Roslyn Barbash, M.D., Chairman, Teaneck

(Reference Committee "G")

The committee focused on continuing education and vocalization at public hearings and forums.

Communication with the county societies urged that at least one meeting be devoted to problems of the environment. Three counties responded as follows:

Bergen held a public forum, co-sponsored by the local newspaper.

Essex passed a resolution to devote one meeting a year to environmental considerations.

Gloucester held a meeting devoted to environmental problems. The county bar association also participated.

The Committee members appeared at the Clean Air Council hearings in 1970 stressing the points made in Resolution #24 (1970 House of Delegates). Testimony has been prepared and witnesses designated for the April 1971 Clean Air Council Hearings.

Approved (page Tr 144)

Maternal and Infant Welfare

John D. Preece, M.D., Chairman, Trenton

(Reference Committee "G")

Last year the Committee requested the Department of Health, Bureau of Vital Statistics, to screen out all female deaths where thrombosis or embolism was cited as a cause of death. It was hoped that we might thus ascertain whether or not the taking of oral contraceptives may be a causative factor in such cases. The Department of Health did conduct such a survey. The results were inconclusive. It appears that significant increases in funding and personnel would be necessary to conduct a proper program. Further consideration of this project will, in view of present priorities, be held in abeyance.

The annual detailed review of maternal deaths indicated that there were 46 such occurrences in 1970. Reports were available, however, in only 20 instances. The Department of Health has announced the appointment of a full time field physician. The Committee is hopeful that through his efforts the previously inadequate system will be corrected.

Approved. It was noted that the field physician referred to is engaged on a part-time basis. (page Tr 144)

CMDNJ And Drug Abuse Programs

The Drug Abuse Institute at Atlantic City, just before our Annual Meeting in May (1971), was cosponsored by the College of Medicine and Dentistry of New Jersey at Newark, by the Pfizer Corporation, and by the Academy of Medicine of New Jersey. Recognizing the Academy as its educational arm, The Medical Society of New Jersey made a donation to the Academy to help develop its educational program and this drug colloquium was one of the several educational projects in which the Academy was involved. The major role of the College of Medicine and Dentistry of New Jersey at Newark was not adequately highlighted in this report. Actually, the College provided two of the Institute's faculty members, provided educational material for distribution, furnished imaginative professional leadership, and, in general, played an indispensable role in the promotion and implementation of the drug abuse program. In the best tradition of the modern medical school—which emphasizes a college's role in community health—the College of Medicine and Dentistry of New Jersey at Newark has really been a pioneer in this field and it is only fair to re-emphasize that at this point.

Administrative Council

Public Relations

John J. Crosby, Jr., M.D., Chairman, Jersey City

(Reference Committee "E")

From time to time the Council on Public Relations re-emphasizes the slogan, "Good Public Relations means Genuine Personal Responsibility." The Council coined and popularized that aphorism years ago to encourage every member of our Society to realize that for good medical public relations there is an indispensable man—the physician himself. The need for that realization was never greater than now, when the popular estimate of physicians in general is arrived at by the critical scrutiny of physicians individually. The Council on Public Relations calls on each member to keep this fact in mind and to do his or her part, faithfully and creditably to demonstrate, by deed and word, the worth and dignity of the character of American Medicine today. It is the basic function of the Council on Public Relations, . . . to evaluate, suggest and—with approval—carry out programs and projects calculated to further the public relations of this Society." It shares the public relations functions, of course, with the President and other officers and officially designated spokesmen, who make or issue statements in the name of the Society. In fulfillment of its assigned functions, the Council this year reviewed and approved the following:

CONTINUING PROJECTS

1) Publication and distribution of:

- a. *Junior Health Hints* to high school teachers of health and to libraries.
- b. *Membership Newsletter*, including the annual compilation of a bound, indexed set to component societies.
- c. *Periodic Newsletter* to cooperating agencies/individuals as required.

2) Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business and interests, including:

- a. The Live Health Screening Program
- b. The Annual Meeting
- c. Child Safety Week
- d. Selected official programs and activities

3) Responsibility for bestowal of the Golden Merit Award

4) Responsibility for the informational center and press releases at the annual meeting

5) Encouragement of continuance—or establishment—of orientation programs for new members under sponsorship of component societies

6) Encouragement of statewide emergency medical care coverage particularly with reference to the "Basic Concepts Underlying the Provisions of Professional Medical Care" as adopted by the 1965 House of Delegates and printed in the "Appendix of Reference Information" of the *Membership Directory*

7) Encouragement of Future Physicians Clubs in each county, through service as a clearinghouse at state level

GOLDEN MERIT AWARD

The 1970 Golden Merit Award was bestowed upon 28 members of the Society, 16 of whom received the award personally in Atlantic City. This brings the total recipients of the Golden Merit Award since its inception in 1957 to 608. Thus far this year, 48 candidates have been nominated by 12 component societies for the 1971 Golden Merit Award. Following the ceremonies this year, the recipients and their families will be guests of the Society at an informal reception, as they have in preceding years.

PR QUESTIONNAIRE

The Council is still receiving, from component societies, completed forms of a comprehensive questionnaire compiled and distributed for the purpose of ascertaining the scope and effectiveness of public relations projects and programs used by the component societies. A digest of the responses will be compiled, on the basis of which the Council hopes to be able to share with component societies PR programs, methods, and techniques which have been proved effective in operation.

Approved (page Tr 137)

Special Committees

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "D")

With the patient load in emergency departments of hospitals increasing annually at a rate of ten per cent or more, continued emphasis was placed by the Committee on the upgrading of such departments.

The Training Program for Emergency Department Physicians, sponsored by MSNJ, in cooperation with the Division of Emergency Health Services, USPHS, and completed, will result in the publication by the Division of a book containing the lecture material presented during this program.

Rapid and safe access to our hospitals is an absolute necessity in the handling of a medical emergency. The Medical Society of New Jersey urged the New Jersey Department of Transportation to place adequate and sufficient road signs on major highways and thoroughfares indicating the location and names of nearby hospitals. In addition, MSNJ recommended that each County Board of Chosen Freeholders coordinate the placing of such signs on county roads with the State Department of Transportation. In this regard, our medical society is receiving excellent cooperation from the State and some of the counties.

One of the major accomplishments by the Medical Society was the excellent cooperation by the hospitals throughout the state in the development of a Statewide Emergency Medical Care Exercise that will be finalized by May 1, 1971. This exercise was developed in cooperation with the Division of Emergency Health Services, USPHS, and the New Jersey Hospital Association. As a preliminary, and to obtain information concerning emergency departments of hospitals, a questionnaire containing 45 questions was forwarded to 140 hospitals in New Jersey. 113 responded, for

an 80 per cent return. Following receipt of the completed questionnaire, a questionnaire scenario type of approach for the exercise was prepared and forwarded to every hospital having an emergency department. The Statewide Emergency Medical Care Exercise, as it is being held in the state, is the first of its kind ever to be held in the United States and may be a pilot exercise for similar programs that can be developed by the Federal Government for the nation. This exercise is to be the first part of a five year projected plan, and it concerns itself primarily with *communications*. In succeeding years, other areas will be considered, such as, *transportation—community organization, manpower staffing, training, and facilities—resources in emergency departments*.

Because of an alarming void in existing emergency procedures on the subject of the emergency treatment of drug abuse victims, it was recommended that the Council on Mental Health consider that subject. The result was the publication in our state medical journal of a paper outlining the treatment of these drug abuse victims.

Various booklets relating to aspects of emergency medical care were distributed to physicians at state and county level, to hospital administrators, nurses and ambulance-rescue squads. These booklets were: "Emergency Handling of Radiation Accidents," "Developing Emergency Medical Services—Guidelines for Community Councils" and "The Treatment of Mass Civilian Casualties." The Committee on Emergency Medical Care strongly urges the development of county emergency medical councils for coordination of emergency medical activities on a day-to-day basis in time of major medical emergencies or disaster. Only in this way can any

community be adequately and properly prepared.

One of the most important subjects entertained was the priority in the nation for funding for Emergency Medical Care. Using the latest statistics available, it was shown that in 1969, 115,000 people died from accidents. Motor vehicle accidents accounted for 56,400 deaths—less than one-half of the total. More people, 62,200 of them, died at work, at home, and at play—suddenly, violently, and without warning. Disabling injuries numbered about 10,800,000, including about 400,000 which resulted in some degree of impairment—ranging from partial loss of a finger to blindness or complete crippling. Emergency Medical Care is in a boom period, not one to be anticipated, but one that is well underway and that will grow for many years to come. This is now taxing the emergency services in every general medical and surgical hospital where emergency departments exist. Ambulance attendants must be upgraded and given improved training by qualified instructors. This should be the responsibility of the component medical societies. It is important that adequate and competent professional medical and allied medical personnel be available in emergency departments of hospitals. In view of the above, the Board of Trustees adopted the following position statement:

That emergency medical care be given a high priority on the National level and that the Federal authorities should provide adequate funds to administer a comprehensive program of emergency medical care.

All New Jersey Senators and Congressmen were then notified of our position and replies received from the legislators were very favorable.

The Board of Trustees then approved the dissemination of our position statement to each state medical society with the request that similar action be taken.

To alert all physicians concerning the storage and dispensing of narcotics and other drugs being used improperly and that are on the Drug Abuse List, the Committee recommended the publication of a paper titled, "Narcotic Don'ts for the Physician."

To supplement the successful Training Program for Emergency Department Physicians previously mentioned, the committee recommended another program for the same emergency physicians working in Emergency Departments of hospitals. This program would also be held in each judicial district to train them in certain highly technical procedures normally performed in these departments.

Approved. Reference Committee urged continuing emphasis on adequate and sufficient road signs to indicate location of nearby hospitals. (page Tr 136)

ACTION TO LIMIT DEBATE

At its first session on Saturday, 15 May, 1971, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject, except by express permission of the House; and that the time be limited to four minutes per speaker, subject to the same exception.

Medicine and Religion

Luke A. Mulligan, M.D., Chairman, Leonia

(Reference Committee "D")

This Committee held no formal meetings in the course of the year. The Chairman addressed the Conference of Presidents and Presidents-Elect of Component Societies last October to urge continued activity on the part of county Committees on Medicine and Religion already established and the creation of such committees in those component societies as have not yet organized them.

sponse of some societies, and it is hoped that the need for increasingly close cooperation between members of our profession and members of the clergy will be progressively recognized and fulfilled, to the end that, working together, the physician and the clergyman may more effectively minister to the patient for his health of body and peace of soul.

It was encouraging to note the interested re-

Approved (page Tr 136)

Project Hope/Vietnam

Thomas C. DeCecio, M.D., Chairman, Cliffside Park

(Reference Committee "B")

At the 1968 Annual Meeting the House of Delegates voted to approve the recommendation of the Board of Trustees, "That Project Hope and Vietnam be established as a joint continuing program of The Medical Society of New Jersey, subject to any subsequent modification by the House of Delegates; and that a maximum of six fellowships be awarded annually on a 'first-come, first-served' basis, each carrying a stipend of \$1,000 for a 60-day tour of duty aboard the S.S. HOPE, her sister-ship, or voluntary service in Vietnam."

six Project Hope Fellowships and two Volunteer Physicians for Vietnam Fellowships.

During the course of the year 1970-71, the following application was received and authorized:

VOLUNTEER PHYSICIANS FOR VIETNAM FELLOWSHIP

John J. Thompson, M.D. (Essex County) . . . \$1,000. Tour of duty in Vietnam—30 December 1969 to 2 March 1970.

To date the society has awarded a total of

Approved (page Tr 133)

1970 TRANSACTIONS

At its first session on Saturday, 15 May 1971, the House of Delegates approved the Transactions of the 1970 House of Delegates as published in the July 1970 issue of THE JOURNAL and distributed to the membership.

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

Since last year's meeting, plans were finalized and, with the approval of the House of Delegates and the Medical Society Board of Trustees, the Prudential Insurance Company's Variable Keogh Retirement Plan and a corporate version were adopted. These will be known as "The Medical Society of New Jersey Plan A, Keogh Version," and "The Medical Society of New Jersey Plan B, the Corporate Version." The trust agreements were drawn up, signed by the members of the Retirement Plan of The Medical Society of New Jersey; IRS approval was obtained in November, 1970. The plan was publicized throughout the Society in December, 1970, and as of the present time, Mr. Blanksteen, representing the Prudential Insurance Company, informs me that twenty-four plans—each plan comprising one or more physicians and in some cases including employees—were adopted. This is in addition to the current operational plans in Essex, which has one hundred nine plans in operation and Union, which has thirty-seven plans in operation. These are all Keogh Version or New Jersey Plan A. Interestingly enough, no corporate plans have as yet been drawn up under any of the State-approved arrangements to date. In addition to the Prudential version, the PRO plan has a Master Keogh Plan involving both a Keogh Version and a Professional Corporation Version.

This report is, in essence, a summation of the two major operational plans having approval

of The Medical Society of New Jersey. We must remind the membership that there are many other plans available, including the AMA Membership Plan and other privately available IRS-approved plans. We emphasize that as many physicians as possible should think in terms of their own retirement needs. They should assess whether individualized plans for retirement are more advantageous than the Keogh Version or the Professional Corporate plans. They should seek legal advice as to the advantages and disadvantages inherent in all of these plans, and then they should act according to their best interests and needs.

Of interest is the fact that Treasury officials have under consideration legislation to end the disparate tax treatment of the retirement programs and to attempt to apply some common denominator between the present Keogh and Corporate standards. This would, in effect, probably curtail some of the benefits available to some incorporated physicians, and it might expand the opportunities for all unincorporated persons. However, the past year has seen no changes in the legislation and the status of planning for retirement remains the same. The message from the Retirement Committee is that every doctor should give serious consideration to his own planning for retirement.

Approved with notation (page Tr 134)

Traffic Safety

Irwin S. Smith, M.D., Chairman, Willingboro

(Reference Committee "D")

The Committee has had no formal meetings this year and thus has no formal report to make to the House.

No action necessary

Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

I am pleased to report that 1970 was a year of growth and measurable accomplishment by the Plan. Although finances reached a low ebb during the year, timely granting of an adequate rate increase by the State Department of Insurance restored the Plan to a relatively stable condition.

In the area of growth, new highs were achieved in several categories:

- (a) *Enrollment* — nearly 45,000 members were gained, bringing the total membership close to 3.5 million and maintaining the Plan's position as fourth largest Blue Shield Plan in the nation.
- (b) *Benefits* — payments to physicians for services rendered amounted to \$83.8 million compared to \$67.3 million in 1969.
- (c) *Services* — the total number of services rendered to members was over two million, up a half million from the previous year.
- (d) *Participation by Physicians* — The Basic Program gained 508 fully-licensed physicians as participants; at year's end the total of Participating Physicians and Laboratories was 7,873, representing approximately four out of every five physicians in the state. The Prevailing Fee Program added 695 fully-licensed Participating Doctors, the total so far is equivalent to about 62% of those eligible in the state. Unfortunately, many physicians are still under the mistaken impression that participation in the Plan's Basic Programs means automatic participation in Prevailing Fee. It also should be kept in mind that increased participation in Prevailing Fee means increased sales of that program to Groups as a replacement for the old Basic coverage.
- (a) *Claims* — Claims on hand were reduced from a volume of 154,000 at the beginning of the year to 60,000 by year's end, by which time 93 per cent of all claims were being paid in 15 days or less. This resulted in a decrease in telephone inquiries and correspondence.
- (b) *Physician's Telephone Inquiries*—During the year, the on-hand volume of inquiries was reduced by 71 per cent, to the lowest figure in the history of the Plan.
- (c) *Correspondence* — The volume of correspondence on hand was reduced by 55 per cent during the year, and correspondence of one month or older was reduced by 87 per cent.
- (d) *Simplified Service Reports* — Short-form Service Reports, slightly larger than an IBM card, were introduced in a pilot program for a number of OB-GYN procedures. These forms proved so successful in reducing the time required by the doctor's office to fill out, and by the Plan to process—thus speeding up payments—that they were adopted as a permanent fixture. The same approach has since been instituted for several common surgical procedures, and will later be put into effect for a number of in-hospital medical care services.
- (e) *Simplified Processing of Blue Shield Claims Complementing Medicare* — A change in the Medicare Part B carrier's Explanation of Benefits form enabled the Plan to process Complementary Coverage Claims direct from the Explanation of Benefits, without requiring a Blue Shield Service Report (except in the case of Federal Employees). The only additional information required is the patient's Blue Shield Identification Number and Physician's Taxpayer Identifying Number, which may be added to the Explanation of Benefits by the physician or patient.

Major innovations in the operations of the Plan resulted in faster payments and better service to physicians and subscribers.

(f) *Tape-to-Tape Claims Processing for Emergency Room Groups* — Arrangements were entered into with one organization, and negotiation started with others, to receive claims for various Emergency Room Groups on tapes that can be processed directly by the Plan's computers. This saves considerable processing time for the Plan and expedites payments.

(g) *Stronger Utilization Control* — The Utilization Control Section mounted an augmented educational program and expanded its program for detecting misutilization of Plan benefits. In several cases where there was definite evidence of repeated fraudulent claims, the Plan acted promptly to report the matter to the appropriate Judicial Committee and, where necessary, the proper legal authority.

The accomplishments of 1970 represent considerable progress by the Plan, which we intend to continue. There are however, two areas that concern the future of the Blue Shield which I believe are of equal concern to the medical profession. They are to a large degree related.

The Blue Shield Usual, Customary and Reasonable Fee Program—known as Prevailing Fee—is being sought by an increasing number of Subscriber Groups who are willing to pay the higher premium required in order to have most of their doctor bills paid in full. We all realize that the Plan's Basic Programs, with their income limits and fixed-fee schedules, no longer provide payment in full to Participating Physicians for covered services except in a minority of cases where the family income is under \$7,500.

By contrast, 95 per cent of the cases submitted under Prevailing Fee are paid in full—directly to Prevailing Fee Participating Doctors. Allow me to stress again that Prevailing Fees are not set by anyone but the doctors themselves. A Prevailing Fee is a physician's usual charge which falls within the customary charge range of at least 90 per cent of his

colleagues in the same type of practice and practicing in the same area. These fees were ascertained through a confidential survey made by the Plan; they have been, and will continue to be, updated.

The advantages of this program to both the Participating Doctor and the Subscriber Group wishing to purchase it seem obvious. But there is currently one hang-up.

Unless more physicians recognize the desirability of participating, the program will not be able to expand as it should. The market is seeking not only paid-in-full coverage, but wide availability of this coverage which requires wide physician-participation in Prevailing Fee. The profession has gone on record many times as favoring a usual and customary fee program over a fixed-fee schedule. Well, it is here—but it needs the all-out support of the profession to make it work properly. Let me emphasize again that this is a separate program which requires separate participation from that of the Basic Programs.

The other area of concern is considerably broader. It relates to the just administration of the Prevailing Fee program which was instituted by Blue Shield and approved by The Medical Society of New Jersey to enable the Plan to pay New Jersey physicians their usual, customary, and reasonable charges for eligible services.

Prevailing Fee claims which cannot be paid in full because a non-participating physician's charges exceed the usual and customary charges for his specialty and area are referred to the judicial mechanism of The Medical Society of New Jersey, unless there has been prior agreement between the non-participating physician and patient as to the charges. This means that a mutual understanding has been created between physician and patient to the effect that (a) the Blue Shield payment may be less than the physician's charges for covered services, and (b) that the patient will be responsible for the difference.

The American Medical Association urges physicians to discuss fees with patients so that the latter may understand and appreciate the value of the service for which a fee is to be paid, either directly by the patient or by his insurance carrier. In the absence of the patient initiating such a discussion, it seems obvious that it is incumbent upon the physician to do so if his charges are greater than the customary charges of physicians in the same type of practice and area. At the present time there is no other circumstance where a fee discussion appears more important to the physician's reputation and the profession's public image.

Other noteworthy events of 1970 included the action of the Board of Trustees, after careful deliberation, in directing the Plan to enter into arrangements for providing prepaid group practice coverage as an alternate choice to fee-for-service. Negotiations have been initiated with several groups already formed or in formative stages. Entry into the prepaid group practice field, so long as subscribers are offered a choice between this type of coverage and fee-for-service, is consonant with the philosophy of the American Medical Association, The Medical Society of New Jersey and the National Association of Blue Shield Plans.

The Board of Trustees accepted with regret the resignation of Joseph I. Echikson, M.D.,

who had served as a Trustee 16 years. Dr. Echikson was named Trustee Emeritus.

John F. Waters, a general representative of the International Brotherhood of Painters and Allied Trades Union, AFL-CIO, a Group enrolled with the Plan, was elected to a three-year term as a Trustee and has contributed substantially to the deliberations of the Board and the work of committees on which he serves.

I wish to express deep personal gratification at the Plan's progress in 1970, made possible by the enlightened guidance of the Board of Trustees and the dedicated loyalty of the staff. It also has been my privilege to share in several of its committees, as well as meeting with several County Societies and specialty groups, and their advice and guidance has been most helpful. In the national scene I have also had the opportunity to serve the National Association of Blue Shield Plans as a Director and Professional Relations Committee Chairman. The latter functions have provided wide exposure to the operations and problems of other Blue Shield Plans, which has reinforced my conviction that the New Jersey Plan—which was founded by the physicians of New Jersey to provide adequate prepaid service-benefits health insurance for the people of New Jersey—is one of the best in the nation.

Comparative Balance Sheet, December 31, 1970

<i>Assets</i>	1970	1969
Cash on Hand and in Banks (Working Funds)	\$ 1,935,753	\$ 1,536,921
Investments	24,836,258	28,285,429
Accounts Receivable—Subscriptions	1,422,409	1,750,072
Accounts Receivable—National Account Program	3,308,559	2,807,632
Accounts Receivable—Federal Employee Program	2,172,178	2,517,905
Accounts Receivable—Other	241,647	179,662
Accrued Interest and Dividends Receivable	330,228	420,337
TOTAL ASSETS	\$34,247,032	\$37,497,958

Liabilities

	1970	1969
Claims Outstanding:		
Reported	\$ 4,172,000	\$ 8,365,000
Unreported	13,553,000	11,150,000
National Accounts	1,583,000	1,297,000
	<u>\$19,308,000</u>	<u>\$20,812,000</u>
Unearned Subscriptions	4,065,458	3,569,979
Accounts Payable—Miscellaneous	1,382,717	1,416,512
Reserve For Group Contract Settlements	2,998,222	2,473,910
Deposits From Other Organizations	972,512	643,145
	<u>\$28,726,909</u>	<u>\$28,915,546</u>
TOTAL LIABILITIES		
<i>Reserves</i>		
Securities Valuation	1970 \$ 753,205	1969 \$ 802,850
Special Contingent	100,000	100,000
Unassigned	4,666,918	7,679,562
	<u>\$ 5,520,123</u>	<u>\$ 8,582,412</u>
TOTAL RESERVES		
TOTAL LIABILITIES AND RESERVES	<u>\$34,247,032</u>	<u>\$37,497,958</u>

Annual Statistics—1970

Table I

Distribution of All Services and Payments

	Total Services	% All Services	Payment	Percent	Payment Per Service
Paid 1970					
Surgical	763,733	36.4	\$36,492,000	47.3	\$47.78
Medical	1,052,517	50.1	24,492,312	31.7	23.27
Obstetrical	47,885	2.3	8,891,115	11.5	185.68
Consultations	64,733	3.1	1,351,857	1.8	20.88
Anesthesia	169,606	8.1	5,961,676	7.7	35.15
Total	2,098,474	100.0	\$77,188,960	100.0	\$36.78

Table II

Distribution of Rider Services and Payments

	Services	% All Services	Payment Amount	Percent	Payment Per Service
Surgical	94,428	13.9	\$ 1,687,696	17.1	\$17.87
Medical	7,145	1.1	367,047	3.7	51.37
Diagnostic X-Ray	259,206	38.3	4,440,896	44.8	17.13
X-Ray Therapy	1,358	0.2	228,069	2.3	167.94
Physical Therapy	16,152	2.4	399,736	4.0	24.75
Pathology	298,923	44.1	2,784,650	28.1	9.32
Total	677,212	100.0	\$ 9,908,094	100.0	\$14.63

Incurred Claims Total for 1970—\$80,370,000

Incidence Rate

Table III

Distribution of Earned Subscription Income

Earned Subscription Income	\$86,927,856	100.0%
Incurred Claims	80,369,777	82.4%
Operating Expense	10,225,147	11.8%
Underwriting (Loss)	(3,667,068)	(4.2)%

Income	\$4,725,740	100.00%
Claims Incurred	4,437,196	93.89
Operating Expense (Estimate)	\$ 288,544	6.11
Gain	249,600	5.28
	\$ 38,944	.83%

FEDERAL EMPLOYEE PROGRAM

Following is a statement of income and expenses, along with utilization statistics of the 1970 experience of the Federal Employee Program.

PAID BASIS

Average Exposure (Persons)	125,854
Services per 1,000 Persons Enrolled	567
Average Cost Per Service	\$ 62.95
Number of Services	71,358
Amount Paid	\$4,492,071

CLAIMS INCURRED

Year	Amount
1970	\$80,369,777
1969	72,580,000
1968	58,536,000
1967	53,016,000
1963	40,991,000
1960	31,516,000
1957	22,886,000
1954	13,992,000
1951	6,527,000
1948	1,204,000
1945	208,000
1942	5,000

INCIDENCE RATE

Cases Per 1,000 Persons Enrolled

Year	Incidence
1970	401
1969	328
1968	304
1967	275
1963	193
1960	166
1957	143
1954	126
1951	112
1948	96
1945	86
1942	40

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

Effective December 1, 1967, the Plan, with the approval of The Medical Society of New Jersey, was designated as contractor for the program, which on the same date adopted a usual and customary charges basis of payment, replacing the fixed fee schedule previously utilized.

Following is the claim experience for 1970.

CLAIMS

Period	Received	Declined	Returned Incomplete
Total Claims 1970	27,884	714	9,476
	Paid		
Claims	Amount		On Hand
16,170	\$1,631,863		749

CITY OF NEWARK MEDICAL PLAN

This Plan, which Medical-Surgical Plan of New Jersey had administered since June 1, 1965, became inoperative with the advent of Medicaid on January 1, 1970.

PUBLIC RELATIONS PROGRAM

The year 1970 was a successful and productive one in the Plan's public relations operations.

The major project of 1970 was adequately justifying the Plan's need for a rate increase, thus minimizing public criticism. In this the Public Relations Office benefited from the cooperation of the State Department of Insurance.

A series of conferences with Department officials achieved agreement on the Plan's proposed presentation of its needs to the public. Arrangements were made with selected media to provide complete information on the rate request in advance of filing, on a confidential basis. This resulted in full and fair coverage when the filing was announced. There was no public criticism, either at the time of the filing or at the rate hearing; the only newspaper which saw fit to comment on the requested 15.1 per cent increase viewed it as not unreasonable. Close relations were maintained with the press during and following the hearing, and the ensuing press articles continued to be generally accurate and fair to the Plan.

In connection with the rate hearing, as well as in other public relations activities during the year, it was pointed out that increases in the Plan's liabilities were due primarily to increased utilization of benefits by subscribers, rather than increases in physicians' fees, and that while the medical profession is attempting to control utilization the effort also requires the cooperation of hospital administrators and beneficiaries of both government and private health insurance programs.

The Public Relations Office was also deeply involved in other communications related to the rate increase. These included preparation of the President's rate presentation and hearing exhibits, communications to subscribers, group officials, and union officials and revision of many forms and items of literature.

In other areas, a highly successful public education/community service program on drug abuse was administered by the Public Relations Office with materials obtained from NABSP.

A booklet, "Drug Abuse: The Chemical Cop-Out" was offered to interested organizations and individuals, free up to 400 copies and at cost thereafter. The response to the booklet, which incidentally has received high praise from the White House on down, was tremendous. Hundreds of requests were received, including those from such organizations as the State Department of Institutions and Agencies, Narcotics Officers' Enforcement Association, State Rehabilitation Commission, Alcoholic Beverage Control Commission, State Police, Jaycees, State Federation of Women's Clubs, and numerous county and municipal narcotics commissions, police and sheriffs' departments and mayors. The booklet was incorporated as the educational medium in a public seminar on drug abuse conducted by the Paterson News—with MSP credited as a sponsor—and was adopted by the Bergen County Narcotics Coordinating Committee as the educational tool for all organizations dealing with drug abuse in that County. In all, approximately 150,000 copies were provided to organizations and individuals. Complementing the booklets were three 16 mm. color and sound films produced by NABSP dealing with the teenage drug scene, the international traffic in narcotics, and the treatment and rehabilitation of addicts.

These were offered free on loan and more than 25 showings were booked by organizations.

Late in the year, a similar program on alcoholism utilizing booklets and films was undertaken, and promised to be equally successful. Both of these programs have generated much goodwill toward the Plan at many statewide levels, and represent extremely fruitful public relations endeavors.

Throughout the year the Public Relations Officer worked closely with the President in

the preparation of communications to the public, including the development of Plan advertising; speeches and communications to the medical profession and medical organizations; and acted as Plan spokesman to media. A new publication, "Blue Shield Newsletter," directed to physicians and their office assistants, was inaugurated. Public Relations continued to exercise editorial supervision over virtually all Plan printed material, internal and external, and provided editorial assistance to all Plan Officers and operating departments in many areas of communications.

PHYSICIAN RELATIONS PROGRAM

During 1970, the Physician Relations Section accomplished its primary objectives of establishing and maintaining liaison and cooperation between the Plan and its Participating Physicians, and maintaining participation at the highest level possible.

The primary tool utilized in the maintenance of our two-way street of communication was the Section's Field Program. Last year, Field Representatives established information desks in the physicians' lounges of 66 hospitals throughout the state. These sessions usually ran from 9:00 A.M. to 2:00 P.M. with the representative answering questions and explaining current Plan policy and procedures. They also made personal visits to 627 doctors' offices—manned exhibits at 6 conventions—addressed 4 specialty society meetings and conducted 61 miscellaneous medical meetings such as emergency room groups, specialty groups, etc.

During the past year we expanded our field activities by establishing strong liaison with Medical Assistants throughout the state. We addressed 20 Medical Assistants' Meetings including Medical Assistants' schools and County Medical Assistants' chapters. In conjunction with the New Jersey Association of Medical Assistants, the Plan sponsored a seminar and a district luncheon meeting. Personnel of the Physician Relations Section are also writing topical articles for the Association's state publication—The Jersey Pulse.

The total number of meetings attended during 1970 was 784. The total number of contacts was 6,045. We are gratified by the interest shown by physicians in our Field Program and would like to take this opportunity to thank them for their continuing cooperation and participation.

It is noteworthy that at year's end the total number of Participating Physicians and Laboratories in the Basic Blue Shield Programs stood at 7,873 or 79.0 per cent of those eligible, a gain over 1969 of 2.4 per cent. This total includes 6,756 Doctors of Medicine, 671 Doctors of Osteopathy and 355 Doctors of Surgical Podiatry.

In the Prevailing Fee Program, the number of Participating Physicians and Laboratories stood at 6,234 or 62.6 per cent, a gain over 1969 of 6.1 per cent. Represented in the total are 5,371 Doctors of Medicine, 504 Doctors of Osteopathy and 284 Doctors of Surgical Podiatry.

The reports of New Jersey Participating and Non-Participating Physicians by County and Specialty (Basic and Prevailing Fee Program), which accompany this report, illustrate the gains within counties and specialties. The total number of Participating Physicians in these programs represents an all-time high in enrollment. Almost without exception, these gains were the result of a personal visit to a doctor's office by a member of the Field Staff. During these visits the Plan's various programs were explained in detail, enabling the physician to make a prompt knowledgeable decision regarding his participation in the Plan's two major programs.

We believe each personal contact made during 1970 helped the medical profession to better understand Blue Shield philosophy, policies and procedures and the Plan's value to the citizens of New Jersey.

UTILIZATION PROGRAM

During 1970, all criteria for a Utilization Re-

view Program set up by the National Association of Blue Shield Plans were met. The New Jersey Plan's program is further advanced than that of most other Plans in the area of underwritten business. It included Basic, CHAMPUS, Federal and Medicare Complementary claims, and resulted in the recapture of over \$40,000 from 42 physicians, with further refunds from 11 physicians totaling over \$61,000 pending at year's end. Since the inception of the program five years ago, more than \$100,000 has been refunded by over 300 doctors.

Flip Chart Presentation. A Flip Chart presentation, explaining the Plan's Utilization Review Program, was given at 28 hospitals in New Jersey. Over 700 physicians attended the presentations. The presentation has led to several other Blue Shield Plans adopting a similar approach.

Utilization Review By Group. During the year, the Utilization Section explored various approaches to reviewing enrolled Groups having a relatively poor claims experience. The work with Groups is essentially educational, utilizing literature and posters which are in the planning stages.

Questionnaires. The Section mailed out an average of 300 subscriber questionnaires each month, obtaining a return of about 65 per cent. When a follow-up was made, returns rose to 85 per cent. The results disclosed a number of discrepancies and pinpointed some areas of practice where continuing scrutiny was indicated. Subsequent questionnaires will be concentrated in these areas.

Laboratories. Fee Schedules were obtained from high volume laboratories and checked against a random selection of claims. Several hundred claims were either reduced in payment or declined as a result of this program.

Anesthesia Arrangements. A survey of 96 New Jersey hospitals indicated that more hospitals are using Registered Nurse Anes-

thetists, with the percentage rising from 59 in 1969 to 64.5 in 1970. An analysis was made of the ratio of doctors to hospital-employed R.N.A.'s. In situations where the ratio of R.N.A.'s was relatively high, further investigation was initiated.

Post-Audit Review of Hospital Charts. Routine audits were made at 104 New Jersey hospitals, 35 of the hospitals receiving two audits. In addition, 17 special audits were made. The audits involved the examination of more than 7500 charts. Claims to be audited were randomly selected, and cases where the probability of error was greatest were reviewed. As a result, the audits were more productive this year than in previous years.

Physician Education. The Utilization Section, in collaboration with Editorial Services and Blue Shield Public Relations Office, is developing a series of messages to physicians directed toward various areas that are susceptible to utilization problems.

In Summary. The objective of Utilization Review is to conserve the subscribers' funds so that necessary medical care may be properly paid for by the Plan. It is felt the Utilization Section in 1970 made progress toward that objective.

ENROLLMENT REPORT

Total membership of Medical-Surgical Plan was increased in 1970 by 44,806 persons; this represented a new gain of 1.3 per cent. This membership gain was the net result of the addition of 29,047 contracts during the 1970 marketing period. Current Plan membership of 3,414,278 persons represents 47.7 per cent of the State's population.

Enrollment under the varied Group programs totals 2,780,247 persons, an increase of 24,259 members over the year-end 1969 total. Within the major categories of coverage in the broad Group classification, the following change in membership exposure are reported: Members covered under the Basic Certifi-

cate, both with and without Rider coverage, total 1,577,860 persons, a decrease of 157,643 members. This decline in community Group enrollment was offset by growth in the more specialized coverage categories. The increase of 73,131 members in the governmental coverages from the 27,160 contracts added, primarily as a result of the 20,896 contract addition to the State Municipal Program, has increased the categories' representation in the total Group population to 15.2 per cent. The National Account category, including the New Jersey Bell and Western Electric accounts, displayed a total membership increase of 36,644 members bringing total exposure under this enrollment segment to 522,452 persons. Subscribers and dependents covered under Domestic Master Contracts totaled 150,318 at year end, an increase of 72,059 over the December 31, 1969 total. More than 60 per cent of this gain was recorded in those Domestic Master Contracts which provided prevailing fee benefits to their members. Enrollment within the Group Complementary coverage categories remained relatively stable throughout the year, at year end reporting a net decrease of only 68 members. In total, 9,357 net contracts were added to the Group category during 1970. During this period also, the number of accounts enrolled increased by 541 to the current total of 16,820.

The Direct Payment categories also displayed the same levels of moderate growth as experienced in the Group classifications. Membership in the Left-Group segment of the Direct Payment population grew by 1,327 persons, this increase being generated from additions to the Basic and Rider J category. Within the Non-Group segment a net gain of 8,571 contracts caused the addition of 11,394 members. A total of 8,802 new members were enrolled under the Basic and/or Basic and Rider J classifications, while under the Student program 2,592 new members were added. The senior citizen population enrolled under the Blue Shield 65 program continued its growth during 1970 with 8,832 new members joining the roles of persons covered under this category. Of the 145,316 persons covered by the

program nearly 70 per cent have also selected the extended benefits rider to supplement this coverage.

With a renewed level of stability being forecast for the economy for the current year it is anticipated that growth in 1971 will show improvement over the 1970 level reported.

ENROLLMENT GROWTH

1970	3,414,278
1969	3,369,472
1967	2,908,799
1963	2,450,755
1960	2,080,582
1957	1,711,834
1954	1,196,804
1951	669,906
1945	236,604
1942	4,131

Comparative Summary of Operations

	1970		1969	
Subscriptions Earned*	\$86,927,856	100.0%	\$81,013,743	100.0%
Less:				
Claims Incurred**	\$80,369,777	92.4	\$72,579,531	89.6
Operating Expenses***	10,225,147	11.8	8,123,986	10.0
	90,594,924	104.2%	80,703,517	99.6%
Gain or (Loss) from Underwriting Operations	\$ (3,667,068)	(4.2%)	\$ 308,226	.4%
Income on Investments	1,617,553		\$ 1,502,066	
Operating Gain or (Loss) for the Year	\$ (2,049,515)		\$ 1,810,292	

*The gain of \$5,914,113 in subscriptions earned reflects gains in enrollment, which increased by 44,806 during the year.

**The rise of \$7,790,246 in claims incurred is attributable to increased exposure from larger enrollment, and to increased incidence, which rose from 328 per 1,000 persons to 401.

***The increase of \$2,099,161 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of \$1,458,151 and an increase of \$641,010 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense increased by 1.8%.

Summary of Reserves for Protection of Subscribers

	1970	1969
Reserves at January 1	\$ 8,582,412	\$ 8,996,816
Operating Gain or (Loss) for the Year	(2,049,515)	1,810,292
	\$ 6,532,897	\$10,807,108
Plus: Reserve Adjustments		
Non-Admitted Assets	\$(574,230)	\$ (80,397)
Adj. of Prior Years Income	(539,000)	181,000
Unrealized Capital Gains	60,368	(223,418)
Claim Reserve	242,000	(1,708,000)
Distribution of Prior Year's Income	322,400	(99,800)
Group Contract Settlement	(524,312)	(294,081)
	(1,012,774)	(2,224,696)
Reserves at December 31	\$ 5,520,123	\$ 8,582,412

New Jersey Participating and Non-Participating Physicians by County—Basic Program

County	PARTICIPATING				NON-PARTICIPATING				% P.P. as of 12-31-70	% P.P. 12-31-69
	Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.
Atlantic	264	255	920	16	14	9	8	1	—	—
Bergen	1226	732	610	72	33	494	482	8	3	1
Burlington	282	257	202	41	12	25	22	3	—	—
Camden	728	634	419	174	35	94	87	5	2	—
Cape May	65	59	44	10	3	6	4	2	—	—
Cumberland	133	126	111	6	6	7	6	1	—	—
Essex	1733	1400	1267	49	67	333	322	6	2	3
Gloucester	155	136	91	33	9	19	17	2	—	—
Hudson	753	628	569	14	37	125	121	1	2	1
Hunterdon	69	64	64	—	—	5	5	—	—	—
Merced	525	438	400	16	17	87	83	4	—	—
Middlesex	574	438	398	16	14	136	130	1	2	3
Monmouth	553	409	375	17	14	144	138	4	2	—
Morris	507	414	367	31	8	93	87	3	2	1
Ocean	195	140	118	15	6	55	51	2	1	1
Passaic	662	486	420	33	27	176	170	3	2	1
Salem	55	51	42	6	2	4	3	1	—	—
Somerset	226	189	178	5	5	37	34	1	1	1
Sussex	70	65	55	8	1	5	5	—	—	—
Union	857	654	547	58	41	203	198	4	1	—
Warren	51	48	43	2	—	3	3	—	—	—
Out of State	274	250	216	29	4	24	24	—	—	—
Total	9957	7873	6756	651	355	2084	2000	52	20	12

New Jersey Participating and Non-Participating Physicians by Specialty—Basic Program

Specialty	PARTICIPATING				NON-PARTICIPATING				% P.P. as of 12-31-70	% P.P. 12-31-69
	Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.
Anes.	433	218	202	16	—	215	210	5	—	—
Derm. Syph.	167	120	120	—	—	47	47	—	—	—
Int. Med.	1459	1122	1089	33	—	337	337	—	—	—
Neur. Surg.	71	43	43	—	—	28	28	—	—	—
Obst. Gyn.	764	568	555	13	—	196	194	2	—	—
Ophth.	315	210	206	4	—	105	105	—	—	—
Orth. Surg.	312	203	196	7	—	109	109	—	—	—
Otol.	207	137	132	5	—	70	69	1	—	—
Path.	193	159	154	5	—	34	33	1	—	—
Ped.	549	485	480	5	—	64	64	—	—	—
Phys. Med.	25	21	20	1	—	4	4	—	—	—
Plast. Surg.	45	16	14	2	—	29	29	—	—	—
Anal. Labs.	123	111	—	—	111	12	—	—	—	12
Proct.	40	23	15	8	—	17	17	—	—	—
Psy. & Neuro.	468	326	320	6	—	142	142	—	—	—
Radiology	293	228	219	9	—	65	65	—	—	—
Surg.	959	741	717	24	—	218	217	1	—	—
Thor. Surg.	46	33	33	—	—	13	13	—	—	—
Urol.	223	121	118	3	—	102	102	—	—	—
Chiroprody	375	355	—	—	—	20	—	—	20	—
General	2890	2633	2123	510	—	257	215	42	—	—
Total	9957	7873	6756	651	355	2084	2000	52	20	12

New Jersey Participating and Non-Participating Physicians by County—Prevailing Fee

County	Total Elig. Phys.	PARTICIPATING				NON-PARTICIPATING				% P.P. as of 12-31-70	% P.P. as of 12-31-69		
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.			D.P.M.	Lab.
Atlantic	264	210	185	12	9	4	54	43	5	5	1	79.5	70.2
Bergen	1226	595	498	60	27	10	631	594	20	9	8	48.5	42.6
Burlington	282	198	156	31	9	2	84	68	13	3	—	70.2	61.4
Camden	728	503	339	131	27	6	225	167	48	10	—	69.0	62.7
Cape May	65	43	34	6	3	—	22	14	6	—	2	66.1	50.0
Cumberland	133	105	93	4	5	3	28	24	3	1	—	78.9	72.5
Essex	1733	1127	1025	39	52	11	606	564	16	17	9	65.0	58.9
Gloucester	155	105	67	27	9	2	50	41	8	—	1	67.7	59.2
Hudson	753	507	460	13	29	5	246	230	2	10	4	67.3	62.5
Hunterdon	69	48	48	—	—	—	21	21	—	—	—	69.5	62.5
Mercer	525	370	339	12	15	4	155	144	8	2	1	70.4	67.0
Middlesex	574	351	315	16	13	7	223	213	1	3	6	61.1	54.0
Monmouth	553	337	312	14	9	2	216	201	7	7	1	60.9	54.6
Morris	507	334	295	25	8	6	173	159	9	2	3	65.8	60.2
Ocean	195	91	78	11	2	—	104	91	6	5	2	46.6	39.0
Passaic	662	401	350	28	20	3	261	240	8	9	4	60.5	56.0
Salem	55	42	35	4	2	1	13	10	3	—	—	76.3	65.6
Somerset	226	154	144	4	5	1	72	68	2	1	1	68.1	51.7
Sussex	70	49	44	4	1	—	21	16	4	—	1	70.0	61.7
Union	857	501	412	48	36	5	356	334	14	6	3	58.4	52.8
Warren	51	44	40	1	—	3	7	6	1	—	—	86.2	81.6
Out of State	274	119	102	14	3	—	155	138	15	1	1	43.7	43.0
Total	9957	6234	5371	504	284	75	3723	3385	199	91	48	62.6	56.5

New Jersey Participating and Non Participating Physicians by Specialty—Prevailing Fee

Ancs.	433	203	189	14		230	223	7		46.8	44.5
Derm. Syph.	167	95	95	—		72	72	—		56.8	56.2
Int. Med.	1459	933	906	27		526	520	6		63.9	62.9
Neur. Surg.	71	35	35	—		36	36	—		49.2	45.6
Obst. Gyn.	764	508	498	10		256	251	5		66.4	63.9
Ophth.	315	170	168	2		145	143	2		53.9	52.3
Orth. Surg.	312	150	144	6		162	161	1		48.0	45.8
Otol.	207	114	109	5		93	92	1		55.0	56.7
Path.	193	92	91	1		101	96	5		47.6	47.6
Ped.	549	363	359	4		186	185	1		66.1	66.6
Phys. Med.	25	13	12	1		12	12	—		52.0	57.1
Plast. Surg.	45	9	8	1		36	35	1		20.0	21.4
Analy. Labs.	123	75	—	—	75	48	—	—	48	60.9	60.5
Proct.	40	25	20	5		15	12	3		62.5	64.1
Psy. & Neuro.	468	275	273	2		193	189	4		58.7	57.6
Radiology	293	182	174	8		111	110	1		62.1	51.3
Surgery	959	609	591	18	—	350	343	7	—	63.5	58.8
Thor. Surg.	46	29	29	—		17	17	—		63.0	64.8
Urol.	223	121	119	2		102	101	1		54.2	54.5
Chitopody	375	284	—	—	284	91	—	—	91	75.7	71.2
General	2890	1949	1551	398		941	787	154		67.4	59.3
Total	9957	6234	5371	504	284	3723	3385	199	48	62.6	56.5

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* Resigned June 30, 1970

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Stanley C. Van Ness, Esq. (1973)
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TRUSTEES EMERITUS

	<i>Appointed</i>	<i>Term as Board Member</i>
Joseph I. Echikson, M.D.	1970	1954-1970
Edward W. Sprague, M.D.	1966	1942-1966
John S. Thompson	1966	1942-1965

ADVISORS TO THE BOARD OF TRUSTEES

	<i>Appointed</i>	<i>Term as Board Member</i>
William F. Costello, M.D.	1958	1948-1958
William E. Dodd, M.D.	1952	1944-1952

FORMER MEMBERS OF THE BOARD OF TRUSTEES

*David B. Allman, M.D. 1945-1945	Joseph P. Donnelly, M.D. 1953-1968	*Royal A. Schaaf, M.D. 1942-1964
*Charles W. Barkhorn, M.D. 1952-1965	*William K. Harryman, M.D. 1944-1945	*Norman M. Scott, M.D. 1942-1950
Irving P. Borsher, M.D. 1950-1965	Sigurd W. Johnsen, M.D. 1942-1948	Reuben L. Sharp, M.D. 1950-1952
*F. Clyde Bowers, M.D. 1961-1963	*Augustus S. Knight, M.D. 1942-1948	James J. Spencer, M.D. 1957-1961
*Theophilus H. Boysen, M.D. 1944-1945	*Thomas K. Lewis, M.D. 1942-1949	Gustave E. Widenmayer 1961-1966
Lewis W. Brown, M.D. 1949-1954	*Arthur W. Lunn 1951-1962	*Carl K. Withers 1952-1961
*William J. Carrington, M.D. 1942-1943	Paul Mecray, Jr., M.D. 1953-1961	David L. Yunich 1962-1963
*Harry N. Comando, M.D. 1942-1958	Duane E. Minard, Jr. 1957-1965	
*Samuel A. Cosgrove, M.D. 1944-1953	Glenn S. Rickert, M.D. 1959-1963	
*Deceased		

Approved (page Tr 134)

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1971 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Atlantic County

Samuel L. Kaman, Atlantic City; Age 69
Frank W. Konzelmann, Somers Point, Age 77

Bergen County

Joseph F. Benjamin, Ridgewood; Age 66
William D. Deuell, Hackensack; Age 62
Abraham Goldfarb, Hohokus; Age 66
Vernon L. Hawes, Ramsey; Age 66
Paul A. Kennedy, Teaneck; Age 70

Burlington County

Michael L. Rachunis, Burlington; Age 65
Paul R. Sparks, Burlington; Age 62

Camden County

Anthony J. Dilelsi, Haddon Heights; Age 67
Henrik W. Locke, Moorestown; Age 56

Cumberland County

Kurt M. Hansen, Millville; Age 59
Anthony Pino, Bridgeton; Age 66

Essex County

M. Jonas Colmer, Elizabeth; Age 67
Ethan T. Colton, Jr., Upper Montclair; Age 67
Joseph C. D'Angelo, Chatham, Mass. (formerly Belleville); Age 61
Anna L. Levy, East Orange; Age 73
A. Gordon Murphy, Montclair; Age 57
Harrold A. Murray, Sea Girt; Age 78
W. Ashton Roberts, Rehoboth Beach, Del. (formerly Caldwell); Age 71

Robert F. Roh, Lakewood; Age 74
Herman W. Schweizer, West Orange; Age 66
Christopher A. Smith, Brookside; Age 61

Hudson County

Samuel I. Kooperstein, Verona; Age 70
Salomon Silvera, Kearny; Age 65

Middlesex County

Stanley A. Gadek, Deltona, Fla. (formerly Perth Amboy); Age 60
Joseph Lang, Miami Beach, Fla. (formerly Perth Amboy); Age 64

Morris County

John M. Atkinson, Madison; Age 63
J. Henry Harrington, Dover; Age 70
Otto Rubens, Dover; Age 69

Ocean County

Willis B. Mitchell, Toms River; Age 65

Passaic County

M. Marvin Cohen, Paterson; Age 61
Nicholas Palma, Brick Town; Age 69
James E. Phelps, Sparta; Age 75
Louis J. Radest, Glen Rock; Age 70
Marguerite A. Schafer, East Paterson; Age 59
Jacob Warren, Furlong, Pa. (formerly Paterson); Age 70

Warren County

G. Homer Bloom, Phillipsburg; Age 75
Timothy H. Spillane, Phillipsburg; Age 75

Approved (page Tr 145)

Supplemental Report

The following additional nominations for election to emeritus membership have been received:

Essex County

Max G. Straus, Maplewood; Age 77
Milton Wurzel, Union; Age 67

Approved (page Tr 145)

MEMORIAL RESOLUTIONS

The following resolutions were received by the House with sorrowful concurrence.

David Bacharach Allman, M.D. (1891–1971)

Whereas, after a long life of distinguished and endearing service as a renowned surgeon and medical leader, our beloved colleague, David Bacharach Allman, M.D., has been called to his eternal reward; and

Whereas, as a dedicated and faithful member of The Medical Society of New Jersey and member and Chairman of its Board of Trustees, Doctor Allman consistently advanced the good name of Medicine and the welfare of the people of New Jersey; and

Whereas, as the 111th President of the American Medical Association, he extended the scope of his service to embrace the nation and the world, and in so doing reflected

singular honor upon our Society and our State; and

Whereas, by his life we were all enriched so by his death we are all impoverished; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring David Bacharach Allman, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved widow in token of heartfelt sympathy.

Louis Stanley Wegryn, M.D. (1903–1971)

Whereas, Almighty God has summoned from our midst His good servant and our beloved colleague, Louis Stanley Wegryn, M.D.; and

Whereas, in his long career as a surgeon of high competence, Doctor Wegryn distinguished himself as one who loved and served his fellowman; and

Whereas, with exemplary and unselfish devotion throughout his entire career, he championed the ideals and humanitarian goals of the medical profession and served well The

Medical Society of New Jersey as a faithful member and able President; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey record its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of the Board and that another copy, suitably prepared, be presented to Doctor Wegryn's bereaved family in token of heartfelt sympathy.

RESOLUTIONS

#1

Fluoridation

From the Somerset County Medical Society

(Reference Committee "A")

Whereas, The Medical Society of New Jersey recognizes dental caries to be a widespread and significant disease in this state; and

Whereas, the controlled fluoridation of public water supplies at approximately one part per million of fluorine is generally recognized by the scientific and medical community to be a safe, effective, and inexpensive method of combating this disease; now therefore be it

RESOLVED, that The Medical Society of New Jersey reiterate its endorsement of controlled fluoridation of public water supplies; and be it further

RESOLVED, that The Medical Society of New Jersey urge the adoption of mandatory controlled fluoridation on a statewide basis by the legislature of the State of New Jersey, as the only practical means of providing this desirable public health service for children and adults of this State.

Foregoing paragraph amended to read:

RESOLVED, that The Medical Society of New Jersey urge enactment of legislation obliging the Department of Environmental Protection to promulgate regulations requiring the fluoridation of public water supplies.

Adopted as amended by the Reference Committee (page Tr 131)

#2

Investigation and Evaluation of Collection Agencies

From the Essex County Medical Society

(Reference Committee "A")

Whereas, the AMA Judicial Council has declared that a "physician should not utilize the service of a collection agency whose tactics and methods of collection will bring the medical profession into disrepute"; and

Whereas, a physician may not know the tactics and methods used by various collection agencies; and

Whereas, the individual physician has neither the time nor the facilities properly to investigate these collection agencies; now therefore be it

RESOLVED, that The Medical Society of New Jersey investigate the major collection agencies soliciting New Jersey physicians' accounts; and be it further

RESOLVED, that a list of approved agencies be periodically published by The Medical Society of New Jersey and distributed to all members.

Rejected as unnecessary (page Tr 131)

Assembly Bill 893, which passed both houses of the Legislature and is awaiting the Governor's signature, will stringently regulate the practices of collection agencies, under the supervision of the office of the Secretary of State.

#3

Liberalization of Abortion Laws

From the Essex County Medical Society

(Reference Committee "A")

Whereas, it is a statistical fact that abortions have been, and will continue to be, performed in a clandestine manner, with serious medical risks to the women involved; and

Whereas, it is also a fact that New Jersey has antiquated laws on abortion that need revision; and

Whereas, with the present trend in sociologic thinking toward allowing abortions to be done more freely, it would appear logical to permit the careful performance of "legal" abortions, by competent medical personnel in approved medical institutions; now therefore be it

RESOLVED, that The Medical Society of New Jersey strongly urge the legislature of the State of New Jersey to draft and pass more liberal and pertinent abortion laws, that include these necessary features:

(a) There be no restriction to the performance of abortion up to the end of the 20th week of pregnancy, except those of good, safe, medical practice.

(b) That the only requirement for the performance of abortion be that the pregnant woman request it, and that her physician agrees her health would safely permit it.

(c) A pregnant woman age 16, but under 21, should not be required to obtain parental or guardian consent for abortion.

(d) Pregnant girls under age 16 should have parental or guardian consent, if available, for abortion, but if this consent is not obtainable, a written concurring opinion by another physician should be considered adequate, with no right to later retraction.

(e) Abortions should be performed only in such areas of hospitals where adequate surgical practice can be assured by competent medical personnel.

(f) No physician shall be required to perform an abortion nor shall any institution be required to allow an abortion to be performed within its walls.

(g) No physician or medical institution can be declared liable for having performed an abortion provided written permission was obtained from the pregnant woman and the procedure was done according to the usual, proper, accepted standards of good medical care.

Not adopted (against: 182; for: 130) (page Tr 131)



House of Delegates—Third Session.

#4

Staff Dispensary for Legislature

From the Essex County Medical Society

(Reference Committee "A")

Whereas, some other state medical societies have offered volunteer physicians to staff a first aid post in the legislatures of their states to assist where needed when the legislative bodies were in session; and

Whereas, this has been successful in achieving a closer working relationship with Senators and Representatives; and

Whereas, The Medical Society of New Jersey has 8,000 members from which enough volunteers could be obtained to each give one day to staff such dispensaries in our State; and

Whereas, this would benefit the legislators and provide us with a better rapport with them and closer working knowledge of legis-

lative process in New Jersey; and

Whereas, this could stimulate interest in some physicians becoming more active politically; now therefore be it

RESOLVED, that The Medical Society of New Jersey inform the New Jersey Senate and the House that we are willing to supply volunteer physicians to man a dispensary when they are in session; and be it further

RESOLVED, that if no dispensary is on premises that MSNJ defray the expense of equipping a room for such purpose.

Rejected (page Tr 131)

President Satulsky presenting plaque, in recognition of the sesquicentennial of the Hunterdon County Medical Society, to Frederick Knocke, Past President of that Society.



#5

Cancellation of HSP Coverage for Surviving Spouse

From Joseph M. Gannon, M.D., Delegate from Union County

(Reference Committee "C")

Whereas, of the many things that currently threaten our security, the possibility of being hospitalized during a period when such hospitalization is not covered by adequate insurance looms as one of the most menacing; and

Whereas, information derived from knowledgeable persons as well as from scrutiny of the Subscription Contract of the Hospital Service Plan of New Jersey seems to indicate that in the situation wherein a Subscriber (a physician-member of the MSNJ Group) carried by the HSPNJ dies, his spouse (wife), who theretofore had been covered as an Eligible Person under a Group Family Contract, immediately has her insurance cancelled; there is nothing in the Contract that appears to deal specifically with this situation but apparently in order to continue any hospitalization insurance with HSPNJ the surviving spouse must make a Non-Group Application, which if accepted excludes her from coverage for any condition which existed prior to the date of application; in any event if a policy is issued it is cancellable on one month's notice; and

Whereas, the foregoing creates a potentially devastating situation which any prudent person would go to great lengths to forestall;

now therefore be it

RESOLVED, that MSNJ re-evaluate the Subscription Contract offered by the Hospital Service Plan of New Jersey to the members of this Society to ascertain if any substantial hazards such as are mentioned in the Preamble of this resolution do in fact exist; and if such are found; be it further

RESOLVED, that MSNJ proceed with greatest vigor and tenacity to effect correction of any situation wherein a surviving spouse of a member of this Society might find herself deprived of hospitalization insurance by the Hospital Service Plan of New Jersey through no action or fault on her part; such action on the part of MSNJ should embrace persuasion, appeal to the Commissioner of Banking and Insurance, litigation, and if necessary the seeking of appropriate legislation to the end that a remedy is found for this seemingly unwholesome situation

Not adopted (page Tr 134)

Reference Committee was assured (by HSP) that adequate concern and coverage are available to surviving spouses and families. The Plan indicated that it will conduct an educational campaign directed toward component society treasurers and/or remitting agents to delineate clearly the proper procedure in this regard.



Scientific Session.

#6

Control of Obscene and Indecent Publications and Displays

From Cumberland County Medical Society

(Reference Committee "E")

Whereas, of late there have been increasing public presentation and display of materials of all kinds which wantonly promote interest in and tolerance for obscenity and indecency; and

Whereas, the purveyors and dispensers of such materials justify their activities as necessary for the preservation of freedom of action and freedom of expression; and

Whereas, in so doing they fail to distinguish between liberty and license; now therefore be it

RESOLVED, that The Medical Society of New Jersey oppose the circulation and unfettered distribution of any material whose prime purpose is obviously to generate lascivious response; and be it further

RESOLVED, that The Medical Society of New Jersey urge that all proper legal steps be taken to control and eliminate the free traffic in such degrading materials.

Not adopted (page Tr 137)

#7

Establishment of New Conjoint State and County Public Relations Program

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, an educated public has the right to be continually informed in an impartial and honest manner of Medicine's points of view; and

Whereas, to accomplish this in an efficient and effective manner requires an ongoing and full-time effort on the part of a well-planned professional public relations program conjointly involving the twenty-one county medical societies and The Medical Society of New Jersey; now therefore be it

RESOLVED, that such a continuous, centralized and active public relations program be established by The Medical Society of New Jersey, and that the Officers and Trustees of

The Medical Society of New Jersey be directed to fund and activate such a program immediately; and be it further

RESOLVED, that an assessment of \$5.00 per member be levied in 1972 to pay specifically for a professional public relations firm to implement a positive, aggressive, coordinated ongoing public relations program to educate the public and the physician in conjunction with state and county public relations committees. This public relations agency is to make regular statewide and local news releases, promote exhibits, school programs, organizational contacts, PTA group education, and be available for the rebuttal of unfavorable publicity; and be it further

RESOLVED, that The Medical Society of New Jersey's Board of Trustees and AMA Delegates recommend a similar program for all 50 states.

RESOLVED, that the Board of Trustees be mandated to establish a continuing public relations program staffed by a full-time public relations counsel or director.

Tabled and referred to Council on Public Relations for further study (page Tr 138)

Resolutions 7 and 22 were considered together, and Reference Committee recommended that Resolution 7 be adopted with the second "Resolved" amended to read:

#8

Legal Immunity for Physicians Making Blood Alcohol Determinations

From the Burlington County Medical Society
(Reference Committee "E")

Whereas, it is generally agreed that the use of alcoholic beverages contributes greatly to death and injury on the highways; and

Whereas, it is necessary for law enforcement officers to request physicians to assist with the performance of blood alcohol determinations; and

Whereas, physicians are often reluctant to comply with such requests because of the possibility of legal action which may be taken against them resulting from such compliance; and

Whereas, the New Jersey Supreme Court's

Committee on Relations with the Medical Profession has taken cognizance of this problem and has expressed understanding of the physicians' dilemma thus produced; now therefore be it

RESOLVED, that The Medical Society of New Jersey seek enactment of state legislation which would provide physicians with immunity from litigation which might arise from compliance with the request of a law enforcement officer for a blood alcohol determination.

Adopted (page Tr 138)

#9

Legislation Concerning Medical Assistants

From the Essex County Medical Society
(Reference Committee "F")

Whereas, physicians are becoming increasingly busy and their dependence on medical assistants necessarily increases; and

Whereas, an alert, well-trained medical assist-

ant can release the physician from the non-medical pressures of his practice; and

Whereas, the AMA and the American Association of Medical Assistants are cooperating in

establishing well-trained and certified medical assistants; and

Whereas, the prohibitory provisions of the New Jersey Medical Practice Act apply to all ancillary personnel except those specifically excluded under section 45:9-21K namely: "a chiropodist, professional nurse, registered physical therapist, masseur, while operating in each particular case under specific direction of a regularly licensed physician or surgeon"; and

Whereas, the current interpretation of the Medical Practice Act in these restrictions regarding medical assistants undermines approved good medical practice by excluding trained allied medical personnel; and

Whereas, this affects almost every physician who uses medical assistants whether in an office, laboratory, hospital, or home; now therefore be it

RESOLVED that The Medical Society of

New Jersey move swiftly toward introduction and passage of legislation pertaining to these prohibitory provisions of the Medical Practice Act and include approved medical assistants (which term includes technicians); and be it further

RESOLVED, that such enactment would insure the continuance of ancillary services presently threatened, the withdrawal of which would result in greatly impaired service to the public of New Jersey; and be it further

RESOLVED, that the State Attorney General make a current interpretation of the Medical Practice Act to permit the legal use of Medical Assistants under the specific direction of a regularly licensed physician or surgeon until such time as the present Medical Practice Act be amended.

Not adopted—referred to Council on Medical Services for further study (page Tr 143)

#10

Legislation to Provide that Blood Transfusing Is a Service Not a Sale

From the Gloucester County Medical Society

(Reference Committee "E")

Whereas, the donation of human blood has long been considered a most praiseworthy act of medical charity; and

Whereas, blood transfusions have been removed from the category of sale of goods with implied warranty by legislative action in several states; now therefore be it

RESOLVED, that The Medical Society of New Jersey endorse the enactment of a similar measure by the New Jersey State Legislature at the earliest possible time.

Foregoing paragraph amended to read:

RESOLVED, that The Medical Society of New Jersey urge enactment of S-752 at the earliest possible time.

Adopted as amended by the Reference Committee (page Tr 138)

#11

Modification of Procedures Affecting Legislation

From the Essex County Medical Society

(Reference Committee "E")

Whereas, The Medical Society of New Jersey has available without charge specialized advice on any medical subject through its many committees, councils, sections, and liaison with specialty societies; and

Whereas, on many occasions the Council on Legislation has taken an action of "Approved," "Disapproved," "Active Support," or "Active Opposition," without consulting the chairman of the appropriate committee; and

Whereas, the Council on Legislation meets unvaryingly on a Thursday afternoon when many physicians and liaison representatives of specialty societies find it impossible routinely to attend; and

Whereas, one council meeting monthly reviewing hundreds of legislative bills cannot possibly follow through with all important ones; and

Whereas, smaller task force committees could carry out action programs by contacting and meeting with committees of the Legislature; and

Whereas, if a bill is submitted which contains objectionable passages, the need for legisla-

tion on the subject should be reviewed and, if necessary, a satisfactory measure drafted so that a task force committee could meet with the sponsors of the objectionable bill and revise and compromise instead of flatly disapproving; now therefore be it

RESOLVED, that The Medical Society of New Jersey completely revamp its legislative structure to provide for the following:

(a) Appointment of action task force subcommittees for specific bills.

(b) Obtaining advice on legislation from specialized sources available.

(c) Holding more frequent meetings on Sundays at periods when legislation is introduced.

(d) Drafting of positive measures to fill legislative voids.

(e) Where inequitable legislation is introduced by other sources, investigate the need for the legislation and, if verified, seek to achieve an acceptable compromise bill.

Approved in principle and referred to Council on Legislation for such implementation as is appropriate—report to be made to the 1972 House of Delegates (page Tr 138)



Reception Honoring President-Elect Davis.

#12

Rescinding Eye Medication Ruling

From the Essex County Medical Society

(Reference Committee "E")

Whereas, the State Attorney General's office has permitted optometrists to use eye medication for diagnostic purposes; and

Whereas, it is felt that the administration of any medication is not without hazard in the form of unwanted side effects and therefore should be properly the province only of licensed physicians and constitute the practice of medicine; and

Whereas, some of these side effects—such as allergic conjunctivitis, cardiac arrest, anaphylactic reactions, glaucoma, iritis, retinal detachment, febrile reactions, and skin rash—are recognizable and able to be treated by physi-

cians only rather than by members of the laity; therefore be it

RESOLVED, that The Medical Society of New Jersey take immediate legal steps to effect the rescission of the Attorney General's ruling permitting optometrists to use eye medication for diagnostic purposes.

Foregoing paragraph amended to read:

RESOLVED, that The Medical Society of New Jersey arrange for the introduction of legislation to prevent optometrists from using eye medication for diagnostic purposes.

Adopted as amended by the Reference Committee (page Tr 138)

#13

Approval Criteria of Joint Commission on Accreditation of Hospitals

From the Passaic County Medical Society

(Reference Committee "F")

Whereas, the Joint Commission on Accreditation of Hospitals has in the past frequently approved hospitals where equipment or plant has been sorely deficient; and

Whereas, the JCAH has always leaned heavily for its approval on the status of medical records alone in a particular institution; and

Whereas, this emphasis on records over physical plant has frequently resulted in great difficulties for the physician staff in its efforts

to improve patient care in various institutions; now therefore be it

RESOLVED, that The Medical Society of New Jersey shall instruct its delegates to the AMA meeting to petition that organization to investigate the method of survey and approval of the JCAH so as materially to enhance the emphasis on plant and equipment status of an institution in its approval survey.

Adopted (page Tr 141)

#14

Development of More Family Physicians

From the Essex County Medical Society

(Reference Committee "F")

Whereas, the diminishing number of physicians entering family practice has created a widespread and serious shortage of family practitioners in New Jersey and throughout the United States; and

Whereas, present and proposed Federal health programs are increasing and will continue to increase the number of people seeking primary health care; and

Whereas, family physicians are already overburdened providing primary health care to the ever-increasing number of people seeking it; and

Whereas, the problems can best be solved by increasing the number and effectiveness of family physicians as soon as possible; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend and actively seek the

implementation of the following plan:

(a) Establishment of Chairs of Family Practice in both Colleges of Medicine and Dentistry of New Jersey to attract into and to train students in family practice, and to provide meaningful ongoing refresher courses in family practice in geographic centers in the state;

(b) Expansion of the facilities of both Colleges of Medicine and Dentistry of New Jersey to enable each to admit and graduate at least 200 students a year as soon as practicable, but not later than 1975; and be it further

RESOLVED, that The Medical Society of New Jersey establish a committee actively to promote this plan to increase the number and effectiveness of family physicians in New Jersey.

Adopted (page Tr 141)



Speaker, House of Delegates—Jesse McCall



President-Elect Davis—Inaugural Address.

#15

Establishment of Alcoholism Detection Clinics

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, chronic alcoholism (Jellinek's Disease) is steadily on the increase and is afflicting nine million people in the United States; and

Whereas, the Assistant Secretary of Health, Education, and Welfare evaluated chronic alcoholism as the nation's number one health problem; and

Whereas, last May S-3538 was introduced to the U. S. Senate and co-sponsored by 38 Senators calling for the establishment within the National Institute for Mental Health, a National Institute for Prevention, Treatment, and Rehabilitation from Chronic Alcoholism and Drug Abuse; and

Whereas, for the past two years the Bergen County Medical Society, in co-sponsorship with *The Record*, New Jersey's third largest daily newspaper, and the National Council on Alcoholism—North Jersey Area, successfully carried out alcoholism detection clinics in six Bergen County hospitals; now therefore be it

RESOLVED, that alcoholism detection clinics be established in each and every county in New Jersey and that each component county medical society take the leadership in endorsing, encouraging, and actively participating in such clinics.

Adopted (page Tr 141)

#16

Establishment of Peer Review Committee to Control Quality and Costs of Health Care Services

From the Essex County Medical Society

(Reference Committee "F")

Whereas, providers and consumers alike in the health industry as well as third party payers and governmental agencies have expressed great concern over the increasing cost of good health care, primarily related to the astronomical rise in hospitalization expense; and

Whereas, these same groups have shown increasing concern for effective utilization of all health services; and

Whereas, they also are all striving to promote quality medical care; and

Whereas, many local medical societies have already demonstrated the value of "peer"

committees reviewing matters pertaining to the above; and

Whereas, the AMA's Council on Medical Services espouses such peer review committees and indeed has provided a handbook with guidelines for their formation; now therefore be it

RESOLVED, that The Medical Society of New Jersey establish a Peer Review Committee following guidelines contained in the "Peer Review Manual" of the AMA's Council on Medical Services and that the Society direct its appropriate component societies to do likewise.

Adopted (page Tr 141)

#17

Invasion of Medical Field by Non-Medical Individuals

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, the American Medical Association has gone on record against an invasion of the medical field by non-medical individuals; and

Whereas, certain members of the dental profession, in particular so-called, "oral surgeons" as non-medical individuals, are independently performing major maxillofacial surgery such as the treatment of complicated fractures of the facial bones including the open reduction of zygomatic fractures often involving the orbit and its contents which may result in serious visual disturbances and loss of vision, the surgery of cleft lip and cleft palate, the treatment of injuries to the soft tissues of the face including malignancies; now therefore be it

RESOLVED, that The Medical Society of

New Jersey urge the American Medical Association to request the Joint Commission on Accreditation of Hospitals to withhold accreditation of hospitals which permit this and similar invasions of the medical field by non-medical individuals; and be it further

RESOLVED, that all hospital administrators, chiefs of surgical services, and all other professional components of each hospital subject to the jurisdiction of the Joint Commission on the Accreditation of Hospitals be advised of this action.

Not adopted (page Tr 142)

Reference Committee declared that "... it is not the responsibility of the Joint Commission on Accreditation of Hospitals to determine professional credentials. This responsibility must be maintained within the medical staff of the hospital concerned."

#18

Physician Shortage and Physician Assistants

From Henry A. Brodtkin, M.D., Delegate from Essex County

(Reference Committee "F")

Whereas, we are facing a health crisis due to the shortage of physicians, particularly family physicians, and influential forces are urging the creation of a new class of "physician assistants" to meet this emergency; and

Whereas, the creation of such a licensed class of practitioners, even under the guise of medical supervision performing many traditional duties of physicians will dilute the quality of medical care increase its cost, create new problems in professional liability and confuse the lines of authority and responsibility; and

Whereas, this problem can best be met by increasing the number of medical colleges, doubling the present size of classes, reducing the present eight year course to five years, and increasing the number of present type of medical technicians; now therefore be it

RESOLVED, that this House of Delegates approve the following plan and urge its endorsement by the Governor and Legislature of New Jersey; namely:

a. That the College of Medicine and Dentis-

try at Newark admit 200 students a year and the College of Medicine and Dentistry at Rutgers be prepared to function at that figure by 1975;

b. That chairs of family practice be established at both medical colleges to stimulate more graduates to enter family practice. These colleges should supervise and conduct meaningful refresher courses for family practitioners in geographic centers in the State;

c. That The Medical Society of New Jersey oppose the licensing of physician assistants by whatever name called, as this will result in an inferior quality of medical service and create many problems of liability and responsibility because of this named medical supervision;

d. That the Society urge the establishment and expansion of more licensed training schools for medical technicians who are presently in great demand in hospitals, laboratories, and physician offices. This will obviate the need for and avoid the problems of medical assistants; and be it further

RESOLVED, that the New Jersey Delegates to the American Medical Association House of Delegates be instructed to recommend the

following proposals of The Medical Society of New Jersey:

a. Objections to the promotion, creation, and licensing of physician assistants, by whatever name called, and urge, instead, measures to increase the number of existing licensed medical technicians who are not permitted to substitute for or perform as physicians:

b. Urge the establishment of more medical colleges and expansion of the present ones to double the present number of medical graduates, and recommend a reduction of the pre-medical course to two years and the four year medical course to three years by shortening vacation periods, at least until the present emergency of physician shortages has been met.

Not adopted—referred to Council on Medical Services (page Tr 142)

Reference Committee pointed out that study will require proper definition of terms, a determination of the needs of the medical profession in the way of medical helpers, the correlation of duties of doctors' helpers with the Medical Practice Act, and cognizance of other pertinent facets. Findings and recommendations should be reported to the Board of Trustees.

#19

Reducing Duration of M.D. Curriculum

From the Essex County Medical Society
(Reference Committee "F")

Whereas, the diminishing number of physicians entering family practice has created a widespread and serious shortage of family practitioners in New Jersey and throughout the United States; and

Whereas, present and proposed Federal health programs are increasing and will con-

tinue to increase the number of people seeking primary health care; and

Whereas, family physicians are already overburdened, providing primary health care to the ever-increasing number of people seeking it, and

Whereas, the problem can best be solved by increasing the number and effectiveness of family physicians as soon as possible; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend that the medical college course be condensed to three years; and

be it further

RESOLVED, that The Medical Society of New Jersey establish a committee to seek the implementation of this resolution.

Adopted (page Tr 1421)



Dinner Dance Honoring President Satulsky.

#20

Restriction of P.L. 89-239 to its Proper Purposes

From the Passaic County Medical Society
(Reference Committee "F")

Whereas, the P.L. 89-239 was enacted in answer to AMA's opposition to the DeBakey report; and

Whereas, the reason for this legislation was to improve the *quality* of care for patients with diseases in the categories of heart disease, cancer, and stroke by improving physician education; and

Whereas, the funds for the Regional Medical Program are now being reduced, thus interfering with the operation of these post-graduate education attempts; and

Whereas, in some areas this curtailment may be justified by the misapplication of R.M.P. effort and money in studying problems of urban health or delivery of care to ghetto areas, which problems are in reality in the field of other governmental agencies and not the concern of the R.M.P.; and

Whereas, this problem needs careful consideration and specific direction by the Secretary

of Health, Education, and Welfare and by the Congress (which has been totally lacking since the program's inception); now therefore be it

RESOLVED, that The Medical Society of New Jersey request a full and thorough examination of this problem, with representatives of the AMA, meeting with concerned governmental agencies and or congress or both, to the end that only the primary function, namely education, be expanded along certain specific program guidelines; and be it further

RESOLVED, that the Delegates of The Medical Society of New Jersey submit a resolution for that purpose to the House of Delegates of the AMA at its next annual meeting.

Not adopted—referred to Council on Medical Services (page Tr 142)

Reference Committee pointed out that study will require proper definition of terms, a determination of the needs of the medical profession in the way of medical helpers, the correlation of duties of doctors' helpers with the Medical Practice Act, and cognizance of other pertinent facets. Findings and recommendations should be reported to the Board of Trustees.

#21

Society Representation on Governmental Planning Councils and Agencies

From the Passaic County Medical Society
(Reference Committee "F")

Whereas, there are many opinions emanating from governmental or pseudo-governmental agencies and planning councils regarding health care facilities; and

Whereas, these opinions are issued in such a fashion as to be interpreted as having legislative authority; and

Whereas, these opinions are arrived at without consultation with the medical pro-

fession; now therefore be it

RESOLVED, that The Medical Society of New Jersey be directed to seek direct representation on all such councils and that the Society be further directed to ask the approval of its concerned component society in all decisions affecting the creation or expansion of health facilities.

Adopted (page Tr 142)

#22

Public Relations

From Essex County Medical Society
(Reference Committee "E")

Whereas, to properly relate to modern communications media it is necessary for a large organization to employ experienced publicity personnel; and

Whereas, discussions and resolutions pertinent to The Medical Society of New Jersey employing such specialized personnel usually revolve around a membership assessment; and

Whereas, assessments in general are unwise and cause bookkeeping problems; and

Whereas, a special assessment for public relations does not look good to those outside the organization; and

Whereas, a new project built on a large assessment may easily be discontinued the following year; and

Whereas, public relations should be an ongoing thing, starting small and developing within a budget of regular dues so that it will not be discontinued a year hence; and

Whereas, professional assistance in convention publicity can be obtained for approximately \$1,500 and a similar amount could conceivably cover P.R. retainers for other programs during the year; now therefore be it

RESOLVED, that The Medical Society of New Jersey establish in its budget for the

coming year the amount of up to \$4,000 to be spent on hiring P.R. personnel on a part-time retainer or fee-for-service basis which would include covering the convention next May; and be it further

RESOLVED, that each April public relations needs be re-evaluated and a specific budget

item be recommended to the House of Delegates for the coming year.

Resolutions 7 and 22 were considered together, and Reference Committee recommended that Resolution 7 be adopted with the second "Resolved" amended to read:

RESOLVED, that the Board of Trustees be mandated to establish a continuing public relations program staffed by a full-time public relations counsel or director.

Tabled and referred to Council on Public Relations for further study (page Tr 138)

#23

Accreditation Bill

From Essex County Medical Society

(Reference Committee "E")

Whereas, bills have been introduced in many state legislatures requiring that all persons licensed in the health care field must be graduates of schools or colleges that have been accredited by an accrediting agency recognized and approved by the National Commission on Accrediting and the Office of Education of the Department of Health, Education, and Welfare; now therefore be it

RESOLVED, that an accreditation bill be introduced in the New Jersey legislature by The Medical Society of New Jersey which would affect the future licensing of all li-

censed health care providers; and be it further

RESOLVED, that nothing contained in such bill shall apply to any person licensed in the health care field in this State on the effective date of such legislation.

Reference Committee recommended adopted of Resolution 23 with the first "resolved" amended to read:

RESOLVED, that The Medical Society of New Jersey take steps to arrange for introduction in the New Jersey Legislature of an accreditation bill which would effect the future licensing of all health care providers.

Tabled (page Tr 138)

Subsequent motion to remove from table was defeated.



His home County Society (Union—Dr. Mincur, President) presents President Satulsky with commemorative gift.

#24

Legislative Approach to Professional Liability

From Essex County Medical Society

(Reference Committee "E")

Whereas, the number of unjustifiable professional liability suits has been rapidly increasing in incidence causing yearly jumps in premiums; and

Whereas, a senate subcommittee viewed increased malpractice suits and higher judgments as a situation which, "threatens to become a national crisis with patients having to pay more for medical services"; and

Whereas, liability laws are governed by state legislation; and

Whereas, medical societies in California, Arizona, Washington, Wyoming, Alaska, and Oregon have shown that state legislation can be changed to help reverse the present unfavorable legal climate toward physicians; and

Whereas, the AMA, for the past four years, has recommended that medical societies and physicians work toward obtaining more favorable liability laws through state legislators; now therefore be it

RESOLVED, that The Medical Society of New Jersey establish a small special committee to work with legislators with the goal of introducing and working toward achieving legislation along the following lines:

Foregoing "Resolved" amended to read: (page Tr 139)

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey appoint an ad hoc committee to consider all items listed in the resolution from (a) through (o) and work toward introduction of as many legislative measures as the Legislature will accept.

a. That if a liability case goes to court and the plaintiff loses, the law require that he pay all expenses, both his own and those of the defendant physician.

b. That we attempt to establish through leg-

islation maximum payment for any malpractice case. (Establishment of statutory ceilings in the damages that may be awarded for various kinds of injury or disability, or if a physician is working in a non-profit hospital or institution which has a maximum liability that he also be provided with this maximum liability protection.)

c. Extend concept of privileged communications to the proceedings and/or records of medical review committees of local medical societies.

d. There shall be no monetary liability on part of and no cause for action for damages shall arise against any member of duly appointed committee of state or local professional society or duly appointed member of a committee of a medical staff of a licensed hospital, provided they are operating pursuant to written and duly adopted bylaws.

e. Require the court upon motion of either party to proceed to a separate trial of the defense of the Statute of Limitations before any other issue of the case is tried, if in an action against a physician or surgeon the answer pleads that the action is barred by the Statute of Limitations.

f. Require that the jury be instructed that plaintiff has burden of proving defendant's negligence, by a preponderance of evidence, and that injury alone does not raise either a presumption or inference of negligence.

g. To specifically provide immunity to members of cardiac resuscitation teams.

h. To provide a good faith provision for

emergency medical care for complications arising from prior care furnished by others.

- i. To permit defendant to file a motion requiring plaintiffs in malpractice actions to file a cost bond of not more than \$500, if there is a showing the claim is frivolous.
- j. To request the legislature to establish a maximum period of seven years from date of treatment of a minor within which an action to recover damages for personal injuries resulting from medical treatment or omissions must be filed.
- k. Legislation to abrogate *res ipsa loquitur* in malpractice cases.
- l. Legislation to require casualty insurance companies providing other liability lines to be required to insure medical malpractice at reasonable premium rates as a condition for doing business in the State.
- m. The introduction of a bill to lessen the

number of actions based upon the theory of lack of informed consent.

- n. Legislation to provide for the downward graduation of contingent legal fees in malpractice cases to replace the present practice of plaintiff's attorneys charging a flat percentage regardless of the settlement or award.
- o. Legislation to provide compulsory medical-legal committee screening before malpractice suit may be instituted, similar to New Jersey Supreme Court voluntary screening subpanel; and be it further

RESOLVED, that this special committee be prepared to meet at the convenience of New Jersey legislators to fully explain the import of each separate bill introduced.

Foregoing resolved amended to read:

RESOLVED, that this ad hoc committee be prepared to meet at the convenience of the New Jersey Legislators to explain fully the import of each separate bill introduced.

Adapted as amended (first and second "Resolved") by the House (page Tr 139)

#25

Fluoridation of Public Water Supplies

From Essex County Medical Society

(Reference Committee "A")

Whereas, The Medical Society of New Jersey recognizes dental caries to be a widespread and significant disease in this state; and

Whereas, the controlled fluoridation of public water supplies at approximately one part per million of fluorine is generally recognized by the scientific and medical community to be a safe, effective, and inexpensive method of combating this disease; and

Whereas, 85 percent of the public water supply in the State of New Jersey comes from large purveyors whose water mains criss-cross multiple communities, thus eliminating the possibility of individual action by a single

community; now therefore be it

RESOLVED, that The Medical Society of New Jersey reaffirm its previous position on the fluoridation of public potable water supplies under regulations promulgated by the Legislature of the State of New Jersey as the only practicable means of providing this necessary public health service for New Jersey children and its people.

Foregoing "Resolved" amended to read:

RESOLVED, that The Medical Society of New Jersey urge enactment of legislation obliging the Department of Environmental Protection to promulgate regulations requiring the fluoridation of public water supplies.

Adapted as amended (page Tr 131)

#26

Assimilation of Osteopaths

From Essex County Medical Society

(Reference Committee "A")

Whereas, the American Medical Association House of Delegates in July, 1969, amended AMA Bylaws so that qualified doctors of osteopathy may be admitted to full active membership in the American Medical Association; and

Whereas, this was done to assure the provision of the best possible health care to the American people and make available to osteopathic students and graduates education of the same high standards as prevail in undergraduate, graduate, and continuing medical education programs; and

Whereas, the AMA House of Delegates suggested that "each county and state medical society may accept qualified osteopaths as active members and thereby provides for their membership in the American Medical Association"; and

Whereas, the AMA House of Delegates suggested that state and county societies and other affected organizations "May proceed to make such Constitution and Bylaw changes as are necessary to implement the foregoing"; and

Whereas, their professional liability experience differs from that of our present membership, a separate premium category would have to be set up so that their premiums would be established to completely carry their experience as a distinct category, much like our present specialist ratings; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey instruct the Committee on Revision of Constitution and Bylaws to prepare suitable amendments for presentation at next year's annual meeting to permit fully licensed doctors of osteopathy to become members; and be it further

RESOLVED, that no other member of the Society be charged any portion of the professional liability premium for licensed doctors of osteopathy but that they carry the entire cost of their experience rating.

Rejected (page Tr 131)

Reference Committee concurs in sentiment expressed by 1970 Reference Committee on the same subject that "time and more felicitous circumstances may make such membership (osteopathic physicians in MSNJ) desirable" and does not accept that the desired changes have yet been brought about.

August in Wyoming

The Annual AMA Congress on Occupational Health will be held at Jackson Lake Lodge in Grand Teton National Park, Wyoming, August 29 and 30, 1971. Topics to be covered include occupational and medical services in small plants, aerospace problems, workmen's compensation laws, mental health in industry, safety in the use of atomic power, physical fitness, problems in rural health, effects of carbon monoxide absorption, and medical safety in the mines. If interested, write to the AMA Department of Occupational Health in Chicago (535 North Dearborn Street).

#27

Adoption of AMA System of Coding and Nomenclature

From Thomas C. DeCecio, M.D., Delegate from Bergen County

(Reference Committee "C")

Whereas, the need for a uniform system of coding and nomenclature to describe accurately the great variety of medical services has never been greater; and

Whereas, the American Medical Association has prepared an accurate and current system of coding and nomenclature; and

Whereas, state medical associations, specialty societies, and others have delayed their own efforts so as to be certain there would be one universal system of description of professional services; now therefore be it

RESOLVED, that The Medical Society of New Jersey House of Delegates support the system of coding and nomenclature of the

American Medical Association; and be it further

RESOLVED, that The Medical Society of New Jersey urge the Medical-Surgical Plan of New Jersey and the fiscal intermediary for Medicare and Medicaid to adopt the AMA system of coding and nomenclature as the universal system for description of medical services.

Foregoing "Resolved" amended to read:

RESOLVED, that The Medical Society of New Jersey recommend that the Medical-Surgical Plan of New Jersey and the fiscal intermediary for Medicare and Medicaid consider the feasibility of adopting the AMA system of coding and nomenclature as the universal system for description of medical services.

Adopted as amended by Reference Committee (page Tr 134)

#28

Joint Commission on Accreditation of Hospitals Confidential Random Survey of Staff Physicians

From Middlesex County Medical Society

(Reference Committee "F")

Whereas, the current system of inspection of hospitals by the Joint Commission of Accreditation of Hospitals does not assure the interested staff physician an opportunity to be heard; and

Whereas, there are matters of concern as to the physical plant and administrative decisions which endanger the health and welfare of patients and personnel alike; and

Whereas, the staff physician has a responsibility to his patients, co-workers, and the general public to maintain standards of high quality

care and safety within the hospital; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Joint Commission on Accreditation of Hospitals to conduct a confidential random survey of staff physicians prior to the inspection of the hospital to be evaluated, to obtain an opinion as to the quality of care rendered in that particular hospital.

Not adopted (page Tr 142)

#29

Physician's Right to Hearing Re Revocation or Suspension of Staff Privileges

From Middlesex County Medical Society

(Reference Committee "F")

Whereas, certain physicians have been subjected to the loss of staff privileges by the arbitrary actions of the medical staffs and hospital administrations; and

Whereas, the physicians in question have not been given an opportunity to be heard nor to defend themselves; and

Whereas, these same physicians have not even been informed of the reasons for their loss of staff privileges; now therefore be it

RESOLVED, that The Medical Society of

New Jersey do all within its power to assure that before a physician's staff privileges are decreased, suspended, or revoked, he be granted a hearing to face his accusers, with the right to legal counsel, and with a transcript to be made of the hearing and made promptly available to all parties affected.

Not adapted (page Tr 142)

Mechanism called for in Resolution 29 has already been established in the "Legal Obligations Affecting Medical Practitioners."

#30

Revision of the Medical Practice Act

From John Scillieri, M.D., Delegate from Passaic County

(Reference Committee "E")

Whereas, ever-increasing demands for medical care and services have placed accentuated attention upon the lack of medical manpower and the existing distribution system; and

Whereas, the Federal Government has recognized the need for additional allied health care personnel and has instituted the Federal Medical Personnel and Training Program in order to increase the supply of allied health personnel; and

Whereas, these personnel will assist the physician in diagnosing disease and effecting treatment thereof; and

Whereas, the functioning of the responsibility for the acts of these individuals is to be the burden of the medical profession; and

Whereas, the Medical Practice Act in effect in New Jersey does not authorize the use of many of these important assistants; now therefore be it

RESOLVED, that The Medical Society of New Jersey form a Committee to act in consultation with the Legislative Analyst to revise the Medical Practice Act so that physicians may lawfully utilize and direct the services of ancillary, paramedical, and allied

health personnel under terms and qualifications to be incorporated in the Medical Practice Act; and be it further

RESOLVED, that the Committee also seek a revision of the Medical Practice Act, through

appropriate channels that would delete paragraph (g) of N.J.S.A. 45:9-21.

Not adopted (page Tr 139)

The committee advocated by Resolution #30 already exists and deletion of N.J.S.A. 45:9-21 (g) would not effect the goals cited in the "Whereases" of this Resolution.

#31

Continuance of MSP-HSP Coverage for Children of Subscriber Physicians

From Mercer County Medical Society

(Reference Committee "C")

Whereas, the majority of physicians of New Jersey are participating physicians of the Medical-Surgical Plan of New Jersey; and

Whereas, this wholehearted participation has made it possible for the continued existence of this Plan; and

Whereas, most physicians are subscribers to the Medical-Surgical Plan and Hospital Service Plan of New Jersey; and

Whereas, the Medical-Surgical Plan removes from the benefits of its subscribers any dependents past the age of 19 years; and

Whereas, the physicians of Mercer County hope that these dependents can remain under group coverage by the Medical-Surgical Plan and Hospital Service Plan of New Jersey; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey concur with the hopes of the Mercer County physicians; and be it further

RESOLVED, that the House of Delegates recommend to the Board of Trustees of the Medical-Surgical Plan of New Jersey, the continuance of group coverage of subscriber physicians' dependent children through four years of college.

Foregoing "Whereas" amended to read:

Whereas, the Medical-Surgical Plan and Hospital Service Plan remove from the benefits of its subscribers any dependents past the age of 19 years; and

Whereas, most of these dependents continue on to college while still remaining full dependents of the subscribers; and

Whereas, the physicians of Mercer County hope that these dependents can remain under group coverage by the Medical-Surgical Plan of New Jersey; now therefore be it

Foregoing "Whereas" amended to read:

Foregoing "Resolved" amended to read:

RESOLVED, that the House of Delegates recommend to the Board of Trustees of the Medical-Surgical Plan and Hospital Service Plan of New Jersey, the continuance of group coverage of subscriber physicians' dependent children through four years of college.

Adopted as amended (page Tr 135)

It was noted that there does exist, at a modest premium, a policy for dependent children over age 19, enrolled as full-time students. Blue Plan representatives expressed willingness to cooperate with individual component societies in devising coverage under a family contract for dependent children, ages 19 through 23. This type of contract, however, cannot be preferentially oriented toward college students in that this would represent an unwarranted limitation.

#32

FDA Policy on Fixed Combination Drugs

From James E. D. Gardam, M.D., Delegate from Essex County
(Reference Committee "G")

Whereas, fixed combination drugs have been used successfully for many years by physicians for their patients; and

Whereas, many fixed combination drugs have produced, in main, no adverse problems when used correctly, but have aided patients to recover from their illnesses; and

Whereas, many experts in medicine and pharmacology have defended the use of fixed combination drugs, stating (a) that the ingredients deserve to be put together in recognized, definite clinical conditions on the basis of their therapeutic and toxic potential, (b) the ratio of ingredients has been shown to work satisfactorily for a significant number of patients, (c) laboratory investigation indicates no pharmaceutical incompatibility of the ingredients, and (d) there is good patient acceptability with possible economic savings; and

Whereas, the American Society of Internal

Medicine, at the 15th Annual Meeting of its House of Delegates, adopted a resolution urging the establishment of a procedure which gives adequate consideration to the experiences, views, and opinions of physicians in clinical practices before condemning or removing drugs from the market; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Federal Drug Administration to reconsider its action of categorically removing all fixed combination drugs from the market; and be it further

RESOLVED, that The Medical Society of New Jersey instruct its delegates to the House of Delegates of the American Medical Association to introduce a resolution to induce the American Medical Association to take like action.

Adopted (page Tr 144)

#33

Baccalaureate Program for Physicians' Associates

From Daniel N. Burbank, M.D., Delegate from Essex County
(Reference Committee "F")

Whereas, Livingston College of Rutgers University has a four year "Baccalaureate Program for Physicians' Associates"; and

Whereas, literature from Livingston College states that graduates of this program will render "primary health care"; and

Whereas, these graduates will be overtrained

to be physicians assistants and undertrained to be primary physicians; now therefore be it

RESOLVED, that The Medical Society of New Jersey disapprove of this type of training program as presently proposed and so inform both New Jersey medical schools.

Adopted (page Tr 143)

#34

Proposed State Board Rule on "Minimum Eye Examination"

From Frank B. Vanderbeek, M.D., Delegate from Passaic County

(Reference Committee "G")

Whereas, the State Board of Medical Examiners proposes to adopt a new rule titled "Minimum Eye Examination" (see below); and

Whereas, that proposed rule imposes a series of inflexible, excessive, and unnecessary procedures upon a licensed physician examining a patient's eye "for either ocular pathology or for correction of a possible visual deficiency," which series if followed in every case would be unduly expensive in terms of the physician's time and the ultimate costs to patients; and

Whereas, violation of the proposed rule would subject the physician to suspension or revocation of his license as guilty of gross malpractice or negligence, with immense adverse effect on the already desperate professional liability insurance situation; and

Whereas, the adoption of the proposed rule would set a precedent for the State Board of Medical Examiners under which it could establish rigid and unrealistic standards and procedures for licensed physicians to follow in all phases of medical and surgical practice, in disregard of the licensed physician's right and responsibility to follow his personal professional judgment; now therefore be it

RESOLVED, that the House of Delegates record The Medical Society of New Jersey as strongly opposing the adoption of the proposed rule or any such other rule as would impose similar arbitrary, unjustifiable, and unsound exactions; and be it further

RESOLVED, that the House direct the Special Committee on the Conservation of Vision, Hearing, and Speech to assist the Executive Committee in preparing a statement

of opposition to the proposed rule, for submission to the Secretary of the State Board of Medical Examiners by 31 May 1971; and be it further

RESOLVED, that the House direct the Executive Committee to assist the President in preparing a second statement, opposing the general precedent inherent in the proposed rule-making activity of the State Board as being invasive of the rights of physicians under their licenses and hazardous to their professional independence, responsibility, and security.

Foregoing resolution amended by addition of final "Resolved", as follows:

; and be it further

RESOLVED, that representatives of the Board of Trustees, the Committee on the Conservation of Vision, Hearing, and Speech, and Legal Counsel be directed to meet with the State Board of Medical Examiners at its next meeting on the second Wednesday in June 1971 actively to oppose the proposed rules on "Minimum Eye Examination."

Adopted as amended (page Tr 144)

PROPOSED RULE PERTAINING TO MINIMUM EYE EXAMINATION

The State Board of Medical Examiners, pursuant to authority of N.J.S.A. 45:9-1 et seq., proposes to adopt a new rule entitled "Minimum Eye Examination." The complete text of the new rule is as follows:

A physician licensed to practice medicine and surgery in the State of New Jersey, in performing an examination of a patient's eye for either ocular pathology or for correction of a possible visual deficiency shall be required to perform completely the following minimum eye examination and shall keep a record of the following conditions of every patient so examined.

1. Complete history relating to ocular conditions
2. Naked visual acuity for each eye
3. Detailed report of the external findings
4. Ophthalmoscopic examination (media, fundus, blood vessels, disc)
5. Visual fields (confrontation)
6. Visual fields, central (after age 40)
7. Tonometry on all patients over 40 years of age unless contra-indicated.

For those patients who are to be given a prescription for corrective lenses, the following additional tests shall be made:

8. Static retinoscopy
9. Amplitude of conversion and accommodation
10. Phoria and duction findings; horizontal and vertical, distance and near
11. Subjective findings

12. Fusion
13. Stereopsis
14. Color vision
15. Prescription given and visual acuity obtained.

Violation of the above ruling may subject the licensee to a suspension or revocation of his license to practice medicine and surgery in accordance with N.J.S.A. 45:9-16 (h).

#35

New Jersey Interagency Council on Smoking and Health

From Arthur A. Goldfarb, M.D., Delegate from Bergen County

(Reference Committee "G")

Whereas, it has now been scientifically established and widely recognized throughout the world that smoking has a cause and effect relationship to the increased incidence, morbidity, and mortality of cancer, heart, and respiratory disease; and

Whereas, the magnitude of this problem is such that it has been carefully estimated that more than 300,000 additional deaths each year are related to smoking, and this relationship of smoking to disease is considered to be the significant public health hazard of our time; and

Whereas, the problem is a challenge to the combined efforts of the medical profession, the public health organizations, and all concerned voluntary health agencies; now therefore be it

RESOLVED, that The Medical Society of New Jersey take leadership in reorganizing a New Jersey Interagency Council on Smoking and Health, including membership from the Medical Society, the Public Health Department of the State of New Jersey, interested state voluntary health agencies, particularly in the field of cancer, heart, and respiratory disease, and the New Jersey State Educational Association; and be it further

RESOLVED, that The Medical Society of New Jersey stimulate such a Council, to conceive, coordinate, and assist in implementing effective programs to: (a) persuade young people not to start smoking, and (b) assist all smokers to withdraw from the habit.

Adopted (page Tr 144)

Newly elected Second Vice-President, James A. Rogers and Mrs. Rogers.



#36

MSNJ Participation in Certificate of Need Activities

From Louis K. Collins, M.D.—Fellow

(Reference Committee "F")

Whereas, the State of New Jersey recently enacted new Certificate of Need legislation which is certain to have an impact on all aspects of health care in this state; and

Whereas, the Commissioner of Health and the new Health Care Administration Board will seek the advice of many groups; and

Whereas, it appears that the New Jersey Regional Medical Program may be one such body for expert consultation; and

Whereas, the Regional Medical Program has already approved and distributed four monographs, i.e., A Manual for Stroke, Recommendations for Cardiovascular Surgical Units, Recommended Standards for Coronary Care

Units, and Recommended Standards for Coronary Cineangiography Units in Community Hospitals, now therefore be it

RESOLVED, that The Medical Society of New Jersey, through its Council on Medical Services or other designated committees, actively engage in these consultative functions, with either the various committees of the Regional Medical Program (Cancer, Stroke, Heart Disease) who formulated the above-mentioned guidelines, or participate and advise by having formal representation on these committees, as has been suggested in writing by the Regional Medical Program of New Jersey.

Adopted (page Tr 143)

#37

Proposed State Board Rule on "Minimum Eye Examination"

From the Hudson County Medical Society

(Reference Committee "G")

Whereas, the State Board of Medical Examiners has proposed a fifteen-step minimum eye examination; and

Whereas, the decision as to the steps necessary for a routine examination is a clinical judgment and a primary responsibility of the physicians; and

Whereas, the requirement to perform tests not necessary for diagnosis will substantially

increase the cost of an eye examination; and

Whereas, there are numerous ocular conditions where the minimum tests listed are not feasible; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively oppose the adoption of the proposal.

Adopted (page Tr 144)

#38

Confidentiality of the Judicial Mechanism

From the Morris County Medical Society

(Reference Committee "A")

Whereas, the communications media seek information from component presidents, or other duly elected officers, in matters pertaining to public disputes involving judicial committee activities; and

Whereas, these officers are prohibited by an anachronistic structure from being party to the deliberations and decisions of the county judicial committees; and

Whereas, the local judicial committee derives from the county society but reports to the State Society, creating an inevitable schism of responsibility; and

Whereas, the ignorance of the duly elected

county officers and representatives creates an inability to communicate with the press in matters of public knowledge, thereby resulting in extremely poor public relations; therefore be it

RESOLVED, that the Constitution of The Medical Society of New Jersey be changed to permit communication between the judicial committee and the executive committee on a county level.

Rejected as unnecessary since the means for communication between the judicial committee and the executive committee on the county level are provided and adequate. (page Tr 132)

#39

Liaison Committees with Fiscal Intermediaries

From the Morris County Medical Society

(Reference Committee "F")

Whereas, the primary object of the practice of medicine is the health and welfare of the patient; and

Whereas, limiting the frequency of physician visits to hospitalized patients and extended care facilities is inimical to the right of the patient to good medical care; and

Whereas, the current liaison mechanism between the individual physician interested in the welfare of his patient and the Prudential Insurance Company of America is a uni-

lateral arrangement inconsistent with the democratic concept of dialogue and good faith; now therefore be it

RESOLVED, that The Medical Society of New Jersey establish state and county committees to communicate with the fiscal intermediary on behalf of member physicians, in order to insure that medical judgment is given adequate consideration.

Adopted (page Tr 143)

#40

Joint JEMPAC Billing

From the Bergen County Medical Society

(Reference Committee "B")

Whereas, the Board of Trustees of The Medical Society of New Jersey has recommended that JEMPAC "aggressively stimulate" *interest by** using means of increasing membership; and

Whereas, both the American Medical Association and the American Medical Political Action Committee (AMPAC) emphasized physician membership *as the first 1971 priority of the PAC movement*;^{*} and

Whereas, nationally 41 states and in New Jersey 4 counties have found that joint voluntary billing (preferentially on the same billhead) has substantially increased physician membership; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey hereby endorses the principle of joint PAC billing; and be it further

RESOLVED, that The Medical Society of New Jersey also encourages and recommends that each component county medical society utilize voluntary joint billing, on the same billhead with their annual dues bill.

Not Adopted because of opposition to joint PAC billing, and because it was the opinion of the Reference Committee that county medical societies may undertake joint billing on a voluntary basis without recommendation from MSNJ. (page Tr 133)

^{*} Italics represent sponsor's revisions.

#41

Separate Department of Mental Health

Edward A. Schauer, M.D., Delegate

(Reference Committee "F")

Whereas, The Medical Society of New Jersey, at its meeting in May 1970, adopted a resolution urging a separate Department of Mental Health and Mental Retardation with a Board-certified psychiatrist as Commissioner thereof; and

Whereas, the report of the Contract Survey Board of the American Psychiatric Association, submitted to the Institutions and Welfare Committee of the New Jersey Senate in February 1971, made specific recommendations about the need for a separate Depart-

ment of Mental Health, headed by a Board-certified psychiatrist; and

Whereas, this Survey Board concluded from their investigation "that the governmental organization in New Jersey does not give the mental health program the visibility, identity, dignity, and support it needs and deserves if it is to provide adequate service to the mentally ill"; and

Whereas, the State Mental Health Program in New Jersey has been without central psychi-

atric leadership for twenty-five months; and

Whereas, the conditions adversely affecting patient care, which prompted the request for the study by an independent professional body, continue to prevail; now therefore be it

RESOLVED, that The Medical Society of New Jersey call upon the Governor to use every resource available to him to create at the earliest possible moment a separate De-

partment of Mental Health, headed by a Commissioner who is a Board-certified psychiatrist; and be it further

RESOLVED, that every delegate report this pressing need to his component society and strongly encourage the individual members to communicate to their legislators the urgency for corrective action.

Adopted (page Tr 143)

#42

Addition of Lay Member to Board of Medical Examiners

From the Monmouth County Medical Society

(Reference Committee "E")

Whereas, the State Board of Medical Examiners of New Jersey for many years has conducted its business and met its responsibilities in a forthright and efficient manner; and

Whereas, changing the method with which this Board is perpetuated, or changing the basic composition of this Board, will offer no improvement in the quality of medical care for the citizenry of our State; and

Whereas, adding a lay member who has a vote to this Board might actually be a disservice to the public, who should be entitled to membership of proven medical knowledge and acumen; now therefore be it

RESOLVED, (1) that The Medical Society of

New Jersey inform the Governor of our dismay and great concern because of the passage of this law, and

(2) that The Medical Society of New Jersey exert all its influence through individual legislators by means of the Council on Legislation, legislative keymen, individual physicians, etc., to reintroduce legislation to change this new law.

Not adopted because MSNJ has informed the Governor of its opposition to the appointment of a lay member to the State Board of Medical Examiners; and, additionally, because the action proposed by this Resolution would be an exercise in futility at the present time. (page Tr 139)



Dinner-Dance Honoring President Satulsky.

#43

Support of HMO Concept

From Irwin S. Smith, M.D., Delegate from Burlington County

(Reference Committee "F")

Whereas, there have been for the past several years, an increasing concern and demand for a reorganization of the delivery of health care services; and

Whereas, President Nixon, in his recent special message on health delivered to the Congress, advocated the need for a greater development of a specific method of delivering health services; and

Whereas, the Department of Health, Education, and Welfare has already committed itself to a substantial expenditure to provide assistance and encouragement for the establishment and expansion of Health Maintenance Organizations; and

Whereas, a Health Maintenance Organization is an organized system of health care which accepts the responsibility to provide or otherwise assure the delivery of an agreed-upon set of comprehensive health maintenance and treatment services for a voluntarily enrolled group of persons in a defined geographic area and is reimbursed through a pre-negotiated and fixed periodic payment

made by or on behalf of each person or family unit enrolled in the plan; and

Whereas, it is anticipated in the State of New Jersey that a tremendous population increase of all age groups will severely tax an already overburdened health delivery system; and

Whereas, there are, in the State of New Jersey, many areas which especially fulfill the geographical and enrollment criteria for development of Health Maintenance Organizations, and some members of The Medical Society of New Jersey wish to explore the possibility for implementation of a Health Maintenance Organization; now therefore be it

RESOLVED, that The Medical Society of New Jersey express its agreement with the concept of a need for some changes in the delivery of health care services, and that The Medical Society of New Jersey provide ethical guidelines consistent with legal aspects where appropriate and pertinent.

Adopted (page 143)



President-Elect D'Elia and Mrs. D'Elia (right).



Executive Director Richard Nixon and Mrs. Nixon (left).

#44

Problems Affecting Internships and Residencies in New Jersey Hospitals

From the Bergen County Medical Society

(Reference Committee "D")

Whereas, in order to meet AMA requirements for accreditation, hospitals are compelled to continue requiring E.C.F.M.G. certification (or an alternative method of meeting AMA regulations) as a prerequisite for acceptance into their training program. By continuing to do this the hospitals may lose all state funds which are important for hospital operation; and

Whereas, hospitals which no longer require E.C.F.M.G. certification for acceptance of interns or residents are in jeopardy of losing AMA approval of their entire graduate medical education program; and

Whereas, hospitals without AMA-approved programs will have great difficulty in obtaining qualified interns and residents and have difficulty obtaining third party reimbursement for a portion of medical education costs; and

Whereas, physicians wishing to obtain specialty board certification will not seek training in a program that is not accredited by the AMA; now therefore be it

RESOLVED, that The Medical Society of New Jersey take note of this situation and request the American Medical Association through its Council on Graduate Medical Education to explore all possible means of resolving this untenable situation.

Amended by insertion of the following "Resolved" to precede the existing "Resolved":

RESOLVED, that The Medical Society of New Jersey reaffirm its stand requiring E.C.F.M.G. certification of interns, and that the Board of Trustees continue to work for repeal of Chapter 112, P.L. 1971 (formerly Assembly Bill 2131); and be it further

Adopted as amended by the Reference Committee (page Tr 136)



Incoming President Davis receives Presidential Plaque from President Satulsky. Mrs. Davis was presented a bouquet of red roses.

REFERENCE COMMITTEES

Reference Committee "A"

Joseph J. Kline, M.D., Chairman

Reference Committee "A" met on Sunday, 16 May 1971, with all members present: Doctors Robert S. Gamon, Jr., Sherman Garrison, Joseph A. Lepree, Nathan J. Plavin, and the chairman. Approximately 40 delegates and members were present to discuss the various items under consideration.

1. President (page Tr 5)

The Committee recommends that the report be approved.

Adopted

2. Board of Trustees (page Tr 15)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved.

a. Committee on Long Range Planning and Development (page Tr 15)

The Committee recommends that the report be approved.

Adopted

b. First-Aid Station for Legislators (page Tr 15)

The Committee recommends that the report be approved.

Adopted

c. Fluoridation of Public Water Supplies (page Tr 24)

The Committee recommends that the report be approved with the last sentence of paragraph four amended to read: ". . . under the aegis of the Department of Environmen-

tal Protection."

Adopted

d. Joint Conference with Presidents and Presidents-Elect of Component Societies (page Tr 16)

The Committee recommends that the report be approved.

Adopted

e. National Bicentennial Celebration (page Tr 16)

The Committee recommends that the report be approved.

Adopted

f. The Active Practice of Medicine (page Tr 16)

The Committee recommends that the report be approved.

Adopted

3. Secretary (page Tr 8)

The Committee recommends that the report be approved.

Adopted

4. Judicial Council (page Tr 28)

After much discussion, the Committee recommends that the report be approved. However, it was suggested by the Chairman of the Judicial Council that "appeal hearings" in the summary on page Tr 29 be corrected to read "formal hearings."

Adopted

In addition, the Committee feels that the attention of the entire membership should be directed to the portions of the report dealing with "Adherence to Regulations" and "On the Avoidance of Grievances and Complaints Alleging Infractions of the Principles of Ethics or the Standards of Professional Conduct," stressing that strict compliance is necessary to preserve a good public image of the physician.

5. Executive Director (page Tr 32)

The Committee recommends that the report be approved. It suggests that on page 2 of the report, the word "remittingly" be corrected to read "unremittingly" in order to preserve the meaning of the sentence.

Adopted

6. Credentials (page Tr 37)

The Committee recommends that the report be approved.

Adopted

7. Resolutions:

a. Fluoridation—Resolution #1 (page Tr 99)

b. Fluoridation of Public Water Supplies—Resolution #25 (page Tr 116)

Because of their similarity, the Committee considered the above resolutions concurrently. While the Committee approves the intent of both resolutions, on the recommendation of Legal Counsel, and because of changes in governmental structure of the State, the Committee recommends that the resolutions be adopted, with the "Resolved" amended to read:

RESOLVED, that The Medical Society of New Jersey urge enactment of legislation obliging the Department of Environmental Protection to promulgate regulations requiring the fluoridation of public water supplies.

Adopted

c. Investigation and Evaluation of Collection Agencies—Resolution #2 (page Tr 99)

The Committee recommends that the resolution be rejected. With Assembly Bill 893 passed by both houses of Legislature and now awaiting the signature of the Governor, this resolution is unnecessary. A-893 will stringently regulate the practices of collection agencies, under the supervision of the office of the Secretary of State.

Adopted

d. Liberalization of Abortion Laws—Resolutions #3 (page Tr 100)

The Committee recommends that the resolution be adopted.

Not adopted (against: 182; for: 130)

e. Staff Dispensary for Legislature—Resolution #4 (page Tr 101)

It is the opinion of the Committee that the intent of the resolution is laudable; however, it is convinced that implementation would present insurmountable problems, including full-time staffing, implications of preferential treatment, etc. The Committee feels that the existing State-provided facilities and services are adequate.

The Committee recommends that the resolution be rejected.

Adopted

f. Assimilation of Osteopaths—Resolution #26 (page Tr 117)

Reporting to the House of Delegates last year, the Special Committee on the Admission of Osteopaths to MSNJ Membership made the following recommendation: "This Committee recommends that the House of Delegates not take action to permit fully licensed doctors of osteopathy to become members of The Medical Society of New Jersey."

Last year, Reference Committee "A" recom-

mended that the report of the Special Committee and its concluding recommendation be approved. The House then approved that report. In presenting its recommendation to the House last year, Reference Committee "A" declared: "In making this recommendation (for approval of the report) Reference Committee "A" does not wish its recommendation to be construed as a categorical objection to the inclusion of fully licensed doctors of osteopathy into The Medical Society of New Jersey; time and more felicitous circumstances may make such membership desirable."

Your present Reference Committee does not accept that the desired changes have yet been brought about and concurs in the sentiments above expressed. It therefore **recommends** that Resolution #26 be rejected.

Adopted

g. Confidentiality of the Judicial Mechanism—Resolution #38 (page Tr 125)

In the light of explanations from representatives of the Judicial Council, the Committee feels that the resolution is unnecessary and

the means for communication between the judicial committee and the executive committee on the county level are provided and adequate.

The Committee **recommends** that the resolution be rejected.

Adopted

Physicians, by the nature of their occupation, are not given to carrying their hearts on their sleeves. Emotion and praise are rarely considered appropriate to medical meetings. We would be remiss, however, if we did not acknowledge and express our gratitude for the dignity, self-sacrifice, devotion to the demands of his office, and that special quality of gentleness and kindness with which Doctor Emanuel M. Satulsky served us during his term as President of The Medical Society of New Jersey. Our thanks go also to all the officers, the members of the Board of Trustees, our Executive Director, and all those dedicated members of our Society who gave so much of their time and energy to promote the welfare of all of us and to respond to the medical needs of our fellow citizens.

Reference Committee "B"

Paul J. Kreutz, M.D., Chairman

Reference Committee "B" met on Sunday, 16 May 1971, with all members present: Doctors Edward A. Jasionowski, Josiah C. McCracken, Jr., Francis A. Pflum, Leopold E. Thron, and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees—Items

a. Ad Hoc Committee on Statewide Auto-

mated Bookkeeping, Accounting, and Billing System (page Tr 16)

The Committee was informed that this item has been investigated and potential costs have been considered.

The Committee **recommends** that the report be approved.

Adopted

The Committee also recommends that a further survey of counties be taken informing them of the cost factors involved and of the advantages accruing from such a system before final action is taken by the Board of Trustees.

Adopted

b. Description of MSNJ's Employees' Pension Plan (page Tr 25)

The Committee recommends that the report be approved.

Adopted

c. Physicians' Relief Fund (page Tr 17)

The Committee agrees in principle with the report and recommends that it be approved.

Adopted

2. Treasurer (page Tr 9)

The Committee noted that the Executive Offices need additional facilities and that an assessment would be required in future years to pay for the cost thereof.

The Committee recommends that the report be approved and commends the Treasurer on a job well done.

Adopted

3. Finance and Budget (page Tr 38)

The Committee recommends that the report be approved.

Adopted

The Committee further recommends that the budget for 1971-72 be adopted in the total sum of \$426,987.00, and that the 1972 assessment be adopted at \$60.00 per capita.

Adopted

4. Medical Student Loan Fund (page Tr 47)

The Committee recommends that the report and its contained recommendations be approved.

Adopted

5. Publication (page Tr 50)

The Committee recommends that the report be approved with commendation to the Editor and his staff.

Adopted

6. Project Hope/Vietnam (page Tr 83)

The Committee recommends that the report be approved and that the program be continued.

Adopted

7. Resolution:

Joint JEMPAC Billing—Resolution #40 (page Tr 126)

The sponsor of Resolution #40 requested that the first two paragraphs of the resolution be revised to read: (*italics indicate sponsors' revision*)

Whereas, the Board of Trustees of The Medical Society of New Jersey has recommended that JEMPAC "aggressively stimulate" *interest by* using means of increasing membership; and

Whereas, both the American Medical Association and the American Medical Political Action Committee (AMPAC) emphasized physician membership *as the first 1971 priority of the PAC movement*; and

The Committee recommends that the resolution be not adopted for the following reasons: (1) The Reference Committee is opposed to the principle of joint PAC billing; and (2) The Reference Committee is of the opinion that each county medical society may undertake joint billing on a voluntary basis with no recommendation from The Medical Society of New Jersey.

Adopted

Reference Committee "D"

Roy A. Morrow, M.D., Chairman

Reference Committee "D" met on Sunday, 16 May 1971, with all members present: Doctors Hillel M. Ben-Asher, Harry R. Brindle, John P. Kengeter, Howard D. Slobodien, and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees—Items

a. Proposed National Academy of the Health Professions for Research and Policy (page Tr 18)

The Committee recommends that the report be approved.

Adopted

b. Special Committee on Traffic Safety (page Tr 27)

The Committee recommends that the report be approved.

Adopted

2. Medical Education (page Tr 45)

The Committee recommends that the report be approved.

Adopted

3. Emergency Medical Care (page Tr 81)

The Committee recommends that the report be approved, with emphasis on adequate and sufficient road signs on major highways and

thoroughfares to indicate the locations and names of nearby hospitals.

Adopted

4. Medicine and Religion (page Tr 83)

The Committee recommends that the report be approved.

Adopted

5. Traffic Safety (page Tr 84)

No report submitted.

6. Resolution:

Problem Affecting Internships and Residencies in New Jersey Hospitals—Resolution #44 (page Tr 129)

The Committee recommends that the resolution be adopted.

Adopted

However, the Committee, in addition, recommends insertion of the following to precede the existing "Resolved":

RESOLVED, that The Medical Society of New Jersey reaffirm its stand requiring E.C.F.M.G. certification of interns, and that the Board of Trustees continue to work for repeal of Chapter 122, P.L. 1971 (formerly Assembly Bill No. 2131); and be it further

Adopted



Scientific Session

Reference Committee "E"

Arthur Bernstein, M.D., Chairman

Reference Committee "E" met on Sunday, 16 May 1971, with all members present: Doctors Donald T. Akey, Rudolph T. DePersia, William A. Dwyer, Jr., Edward Foord, and the chairman. Approximately 46 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees—Items

a. Committee on Extension to Interns and Residents of Power to Sign Certain Legal Documents (page Tr 18)

The Committee recommends approval of this report and urges further efforts be made to receive a final opinion from the Attorney General.

Adopted

b. Health Careers Exhibit (page Tr 19)

The Committee recommends that the report be approved.

Adopted

c. Legislative Approach to Malpractice (page Tr 20)

The Committee recommends that the report be approved.

Adopted

d. Medical-Legal Liaison Committee (page Tr 20)

The Committee recommends that the report be approved.

Adopted

e. Opposition to the Legalization of Marijuana (page Tr 20)

The Committee recommends that the report be approved.

Adopted

f. Special Committee on Politics and Medicine (page Tr 27)

This portion of the report provoked considerable discussion primarily for the purposes of clarification.

The Committee recommends that the report be approved.

Adopted

2. Legislation (page Tr 54) and supplemental #1 (page Tr 61) and #2 (page Tr 63)

The Committee recommends the approval of the entire report of the Council on Legislation.

Adopted

3. Public Relations (page Tr 80)

The Committee recommends that the report be approved.

Adopted

4. Resolutions:

a. Control of Obscene and Indecent Publications and Displays—Resolution #6 (page Tr 103)

By a vote of 4 to 1 the Committee recommends that this resolution be adopted, with the final "RESOLVED" amended to read:

RESOLVED, that The Medical Society of New Jersey urge the enactment of legislation controlling traffic in such degrading materials.

Not Adopted

(The Committee member voting against this resolution felt that this is a controversial issue now being argued in the Courts and is not a proper concern for this body.)

b. Establishment of New Conjoint State and County Public Relations Program—Resolution #7 (page Tr 103)

c. Public Relations—Resolution #22 (page Tr 113)

Resolutions #7 and #22 were considered jointly since they both were concerned with the same subject. The Committee decided to recommend that Resolution #7 be adopted with the second "RESOLVED" amended to read:

RESOLVED, that the Board of Trustees be mandated to establish a continuing public relations program staffed by a full-time public relations counsel or director.

The Committee recommends that the resolution, as amended, be adopted.

Tabled and referred to the Council on Public Relations for further detailed study.

d. Legal Immunity for Physicians Making Blood Alcohol Determinations—Resolution #8 (page Tr 104)

The Committee recommends that the resolution be adopted.

Adopted

e. Legislation to Provide that Blood Transfusing Is a Service Not a Sale—Resolution #10 (page Tr 105)

The Committee recommends that the resolution be adopted with the "RESOLVED" amended to read:

RESOLVED, that The Medical Society of New Jersey urge enactment of S-752 at the earliest possible time.

Adopted

f. Modification of Procedures Affecting Legislation—Resolution #11 (page Tr 106)

This resolution provoked considerable and extensive discussion with many delegates voicing their discontent with the present manner of scheduling meetings and lack of reporting by keymen.

The Committee recommends that this resolution be approved in principle and referred to the Council on Legislation for review and for such implementation as appears appropriate, and that a report be made to the House of Delegates next year.

Adopted

g. Rescinding of Eye Medication Ruling—Resolution #12 (page Tr 107)

The Committee recommends that the resolution be adopted with the "RESOLVED" amended to read:

RESOLVED, that The Medical Society of New Jersey arrange for the introduction of legislation to prevent optometrists from using eye medication for diagnostic purposes.

Adopted

h. Accreditation Bill—Resolution #23 (page Tr 114)

The Committee recommends that the resolution be adopted with the first "RESOLVED" amended to read:

RESOLVED, that The Medical Society of New Jersey take steps to arrange for introduction in the New Jersey Legislature of an accreditation bill which would affect the future registration of all health care providers.

Tabled—subsequent motion to remove from table was lost

i. Legislative Approach to Professional Liability—Resolution #24 (page Tr 115)

The Committee recommends that the resolution be adopted with the first and second "RESOLVED" amended to read:

(First)

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey appoint an ad hoc committee to consider all pertinent items listed in the resolution from items (a) through (o) and take appropriate action.

Foregoing amended by the House as follows:

Delete "pertinent," "items" and "take appropriate action" from the first "RESOLVED" and add "work toward introduction of as many legislative measures as the Legislature will accept." The amended "RESOLVED" reads:

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey appoint an ad hoc committee to consider all items listed in the resolution from (a) through (o) and work toward introduction of as many legislative measures as the Legislature will accept.

(Second)

RESOLVED, that this ad hoc committee be prepared to meet at the convenience of the New Jersey Legislators to fully explain the import of each separate bill introduced.

Adopted as amended by the House.

j. **Revision of the Medical Practice Act—Resolution #30** (page Tr 119)

The Committee recommends that the resolution be not adopted for the reason that the Committee advocated by this resolution already exists and, further, that deletion of N.J.S.A. 45:9-21 (g) would not effect the goals cited in the "Whereases" of this resolution.

Adopted

k. **Addition of Lay Member to Board of Medical Examiners—Resolution #42** (page Tr 127)

The Committee recommends that the resolution be not adopted for the reason that The Medical Society of New Jersey informed the Governor of its opposition to the appointment of a lay member to the State Board of Medical Examiners and additionally because the action proposed by this resolution would be an exercise in futility at the present time.

Adopted

Reference Committee "F"

John J. Thompson, M.D., Chairman

Reference Committee "F" met on Sunday, 16 May 1971, with all members present: Doctors Vincent H. Gillson, Peter H. Marvel, William R. Muir, Joshua N. Zimskind, and the chairman. Approximately 50 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees—Items

The Committee recognized the amount of diligent work by the Board of Trustees as documented in their reports and commends their efforts.

a. **Criteria Used by Fiscal Intermediaries in Reviewing Physicians' Services** (page Tr 20)

The Committee recommends that this portion of the report be approved and urges the fiscal intermediaries to notify the physicians of their policy changes by direct and prompt communication.

Adopted

b. **Establishment of Office of Professional Medicare Liaison within Prudential Insurance Company** (page Tr 21)

The Committee recommends that this portion of the report be approved.

Adopted

c. Internships (page Tr 21)

The Committee recommends that this portion of the report be approved and notes with regret that our New Jersey Delegation's efforts at the AMA were to no avail.

Adopted

d. Medicare Billing Forms (page Tr 21)

The Committee recommends that this portion of the report be approved.

Adopted

e. Medicare Peer Review Committee (page Tr 22)

The Committee recommends that this portion of the report be approved and urges the peer review concept be oriented to function with the State committee following initial scrutiny at the county medical society level.

Adopted

f. Payment for Physicians' Services in Out-Patient Department for Recipients of Title XIX (page Tr 22)

The Committee recommends that this portion of the report be approved and feels that guidelines could be formulated at the State level that would be helpful to hospitals and physicians in determining an individual choice.

Adopted

g. Physicians' Exclusive Right to Render Medical Judgments (page Tr 23)

The Committee recommends that this portion of the report be approved.

Adopted

h. Separate Department of Mental Health (page Tr 27)

The Committee recommends that this portion of the report be approved.

Adopted

2. Medical Services (page Tr 64)

The Committee wishes to note the great amount of work and detail that Doctor Collins and his Council on Medical Services have performed.

a. Repeal of Antisubstitution Laws (page Tr 64)

The Committee recommends that this portion of the report be approved.

Adopted

b. Bennett Amendment—Medicare—Medicaid (page Tr 64)

The Committee recommends that this portion of the report be approved.

Adopted

c. Fee Inequities Under Medicare and Medicaid (page Tr 64)

The Committee recommends that this portion of the report be approved.

Adopted

d. Formation, Functioning, and Responsibilities of Utilization Review Committees (page Tr 64)

The Committee recommends that this portion of the report be approved but recommends that a change be made in the paragraph labeled "Preamble" in the third from last sentence, from the words "Judicial Council" to "Judicial Committees." The Committee points out that this provides a logical mechanism for Utilization Review proceeding from the hospital to the County and then to the State.

Adopted

e. Relative Value Index (page Tr 65)

The Committee recommends that this portion

of the report be approved and points out that the index should be used only as a guideline for the physician.

Adopted

3. Occupational Health, Workmen's Compensation, and Rehabilitation (page Tr 66)

No report submitted.

No action necessary

4. Mental Health (page Tr 67)

The Committee wishes to thank the members of the Council on Mental Health for their diligent work over the past year.

The Committee recommends that this portion of the report be approved and urges the continued efforts as cited in the recommendation noting the opposition to the unsupervised practice of psychiatric modalities.

Adopted

5. Alcoholism (page Tr 68)

The Committee wishes to thank the Committee on Alcoholism for their report and efforts over the last year.

The Committee recommends that this portion of the report be approved.

Adopted

6. Drug Abuse (page 70)

The Committee wishes to thank the Committee on Drug Abuse for their report and work during the past year.

The Committee recommends that this portion of the report be approved.

Adopted

7. Emotional Disorders of Childhood and Adolescence (page Tr 71)

The Committee recognizes the interest and efforts of this Committee and wishes to thank

them.

Adopted

8. Mental Retardation (page Tr 72)

No report submitted.

No action necessary

9. Seizures (page Tr 72)

The Committee recommends that this portion of the report be approved and concurs with the recommendation of the Council on Mental Health that the name of the Committee be changed to "The Special Committee on Neurological and Related Disorders."

Adopted

10. Resolutions:

a. Approval Criteria of Joint Commission on Accreditation of Hospitals—Resolution #13 (page Tr 107)

The Committee recommends that the resolution be adopted.

Adopted

b. Development of More Family Physicians—Resolution #14 (page Tr 108)

The Committee recommends that the resolution be adopted.

Adopted

c. Establishment of Alcoholism Detection Clinics—Resolution #15 (page Tr 109)

The Committee recommends that the resolution be adopted.

Adopted

d. Establishment of a Peer Review Committee to Control Quality and Costs of Health Care Services—Resolution #16 (page Tr 109)

The Committee **recommends** that the resolution be adopted.

Adopted

e. Invasion of Medical Field by Non-Medical Individuals—Resolution #17 (page Tr 110)

The Committee feels that it is not the responsibility of the Joint Commission on Accreditation of Hospitals to determine professional credentials. This responsibility must be maintained within the medical staff of the hospital concerned.

The Committee **recommends** that the resolution be not adopted.

Adopted

f. Physician Shortage and Physician Assistants—Resolution #18 (page Tr 110)

The Committee **recommends** that this resolution be referred to the Council on Medical Services for evaluation, study, and implementation. Study will require proper definition of terms, a determination of the needs of the medical profession in the way of medical helpers, the correlation of the duties of doctors' helpers with the Medical Practice Act of New Jersey, and the cognizance of other pertinent facets. Findings and recommendations should be promptly reported to the Board of Trustees for action.

Adopted

The Committee **recommends** that the resolution be not adopted.

Adopted

g. Reducing Duration of M.D. Curriculum—Resolution #19 (page Tr 111)

The Committee **recommends** that the resolution be adopted.

Adopted

h. Restriction of P.L. 89-239 to its Proper Purposes—Resolution #20 (page Tr 112)

The Committee **recommends** that the resolution be referred to the Council on Medical Services for the same reasons cited under resolution #18.

Adopted

The Committee **recommends** that the resolution be not adopted.

Adopted

i. Society Representation on Governmental Planning Councils and Committees—Resolution #21 (page Tr 113)

The Committee **recommends** that the resolution be adopted.

Adopted

j. Joint Commission on Accreditation of Hospitals Confidential Random Survey of Staff Physicians—Resolution #28 (page Tr 118)

The Committee **recommends** that the resolution be not adopted.

Adopted

k. Physician's Right to Hearing Re Revocation or Suspension of Staff Privileges—Resolution #29 (page Tr 119)

The Committee notes that the mechanism of this has already been established in the "Legal Obligations Affecting Medical Practitioners."

The Committee **recommends** that the resolution be not adopted.

Adopted

l. Baccalaureate Program for Physicians' Associates—Resolution #33 (page Tr 121)

The Committee **recommends** that the resolution be referred to the Council on Medical Services for the same reasons as cited under Resolutions #18 and #20.

Rejected

The Committee recommends that the resolution be not adopted.

Rejected

Resolution #33 was adopted by action of the House.

m. MSNJ Participation in Certificate of Need Activities—Resolution #36 (page Tr 124)

The Committee recommends that the resolution be adopted.

Adopted

n. Liaison Committees with Fiscal Intermediaries—Resolution #39 (page Tr 125)

The Committee recommends that the resolution be adopted.

Adopted

o. Separate Department of Mental Health—Resolution #41 (page Tr 126)

The Committee recommends that the resolution be adopted.

Adopted

p. Support of HMO Concept—Resolution #43 (page Tr 128)

The Committee recommends that the resolution be adopted.

Adopted

q. Legislation Concerning Medical Assistants—Resolution #9 (page Tr 104)

The Committee recommends that the resolution be referred to the Council on Medical Services for further study.

Adopted

The Committee recommends that the resolution be not adopted.

Adopted

The Committee wishes to thank all members of The Medical Society of New Jersey for their attendance and their contributing opinions. We wish to thank Dr. Collins and Dr. Jehl, past presidents of our Society, and Dr. Benz, a member of the Board of Trustees, for their attendance and help. We wish to thank Dr. Raymond T. Holden, a member of the AMA Board of Trustees, for his appearance and participation.

A special thanks to the great members of this Committee from their chairman.

Reference Committee "G"

Robert J. Neville, M.D., Chairman

Reference Committee "G" met on Sunday, 16 May 1971. Four of the five members were present: Doctors Nicholas G. Demy, Eugene H. Kain, Carl W. Pflug, and the chairman. Approximately 40 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees—Item

Hazards of Air Pollution (page Tr 23)

The Committee recommends that the report be approved.

Adopted

2. Public Health (page Tr 73)

The Committee recommends that the report be approved.

Adopted

3. Cancer Control (page Tr 75)

The Committee agrees in principle with the report of the Committee on Cancer Control but feels that the statement suggesting that proctosigmoidoscopic and pap tests be routine for all new patients over 30 years of age should be dealt with in greater detail.

The Committee recommends that the report be approved.

Adapted

4. Child Health (page Tr 76)

The Committee recommends that the report be approved.

Adapted

5. Conservation of Vision, Hearing, and Speech (page Tr 77)

The Committee recommends that the report be approved.

Adapted

6. Environmental Health (page Tr 78)

The Committee recommends that the report be approved.

Adapted

7. Maternal and Infant Welfare (page Tr 79)

The Committee recommends that the report be approved, with the notation that it has been informed that the field physician referred to is engaged on a part-time basis.

Adapted

8. Resolutions:

a. FDA Policy on Fixed Combination Drugs—Resolution #32 (page Tr 121)

The Committee recommends that the resolution be adopted.

Adapted

b. Proposed State Board Rule on "Minimum Eye Examination"—Resolution #34 (page Tr 122)

The Committee recommends that the resolution be adopted.

Resolution #34 was amended by the House by the addition of a fourth "Resolved," as follows:

; and be it further

RESOLVED, that representatives of the Board of Trustees, the Committee on Conservation of Vision, Hearing, and Speech, and Legal Counsel be directed to meet with the State Board of Medical Examiners at its next meeting on the second Wednesday in June 1971, actively to oppose the proposed rules on "minimum eye examination."

Adopted as amended by the House.

c. New Jersey Interagency Council on Smoking and Health—Resolution #35 (page Tr 123)

The Committee recommends that the resolution be adopted.

Adopted

d. Proposed State Board Rule on "Minimum Eye Examination"—Resolution #37 (page Tr 124)

The Committee recommends that the resolution be adopted.

Adopted



First Vice-President Boylan and Mrs. Boylan.

Reference Committee "H"

Bernard D. Pinck, M.D., Chairman

Reference Committee "H" met on Sunday, 16 May 1971, with all members present: Doctors Warren E. Crane, Myles C. Morrison, Jr., E. Spencer Paisley, Francis E. Rieman, and the chairman. A small number of interested delegates and members were present to discuss the various items under consideration.

1. Board of Trustees—Item

FAA Medical Examination Form (page Tr 23)

The Reference Committee urges that continued action be taken to pursue the position of the AMA regarding the FAA Medical Examination Form.

The Committee recommends that the report be approved.

Adopted

2. Annual Meeting (page Tr 33)

The Reference Committee commends the Committee on Annual Meeting not only for the current program but for changes in the format and innovations made this year.

The Committee recommends that there be further measures investigated for the streamlining of the annual meeting and that a special appeal be made to the younger members of the Society for their participation in the

annual meeting.

Adopted

The Committee recommends that the report be approved.

Adopted

3. Honorary Membership (page Tr 37)

No report was presented because no nominations had been submitted.

4. Woman's Auxiliary Advisory (page Tr 53)

The Committee commends the Woman's Auxiliary for its active program of the preceding year. The Committee urges continued and further expansion of their activities and especially the drug abuse program.

The Committee recommends that the report be approved.

Adopted

5. Nominations for Emeritus Membership (page Tr 97) and supplemental (page Tr 97)

The Committee recommends that the report be approved.

Adopted



Dr. Raymond Holden, AMA Board of Trustees, addressing the House (left).

Vice-Speaker Mineur and Mrs. Mineur (right).



Reference Committee on Constitution and Bylaws

Robert H. Areson, M.D., Chairman

Reference Committee on Constitution and Bylaws met on Sunday, 16 May 1971, with all members present: Doctors Richard B. Berlin, C. Spencer Davison, Raymond A. McCormack, Jr., Frederick C. Steller, and the chairman. A small number of interested delegates and members were present to discuss the various items under consideration.

Revision of Constitution and Bylaws (page Tr 51)

a. Referral from the 1970 House of Delegates (page Tr 51)

The Committee recommends that the report be approved.

Adopted

b. Physicians' Relief Fund (Bylaw Amendment—Exhibit #1, page Tr 51)

The Committee recommends that the proposed Bylaw amendment be approved. (In

accordance with Chapter XII (Amendments to the Bylaws) favorable action on this Bylaw amendment by the House of Delegates requires "adoption of the report of the Reference Committee by a 2/3 vote of the members of the House of Delegates present and voting at the final session.")

Adopted

c. Appointment of Vice-Speaker (Constitutional Amendment—Exhibit #2, page Tr 52)

The Committee recommends that the proposed Constitutional amendment be approved. (In accordance with Article XII (Amendments to the Constitution), under the heading of the Procedure for First Year, favorable action on this Constitutional amendment by the House of Delegates requires "adoption of the report of the Reference Committee by a majority vote of the members of the House of Delegates present and voting at the final session").

Adopted



Incoming President Davis and Mrs. Davis—
Reception in their Honor.



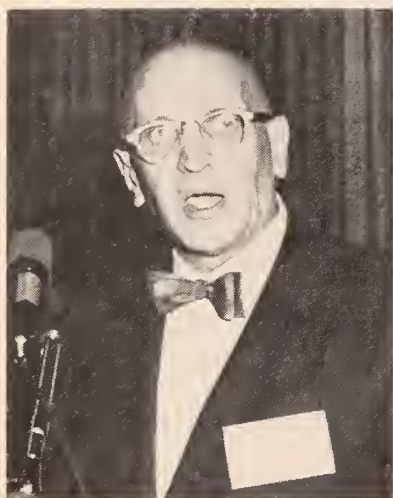
Mrs. Donald McLean, Incoming Auxiliary President,
and Dr. McLean.

Report of Nominating Committee and Election—May 16, 1971

Nicholas A. Bertha, M.D., Chairman

OFFICE	TERM	NOMINEE AND COUNTY
President-Elect	1 year	William J. D'Elia, M.D., Monmouth
1st Vice-President	1 year	Matthew E. Boylan, M.D., Hudson
2nd Vice-President	1 year	James A. Rogers, Passaic
Secretary	1 year	Louis F. Albright, Monmouth
Treasurer	1 year	Samuel J. Lloyd, Mercer
Trustees:		
1st District	3 years	George L. Benz, Essex
2nd District	3 years	James S. Todd, Bergen
2nd District	1 year	Richard F. Lang, M.D., Passaic*
5th District	3 years	Nicholas E. Marchione, Cumberland
Judicial Councilors:		
2nd District	3 years	John L. Olpp, Bergen
5th District	3 years	John S. Madara, Salem
AMA Delegates:	2 years	Joseph P. Donnelly, Hudson
	2 years	Jesse McCall, Sussex
	2 years	Isaac N. Patterson, Gloucester
AMA Alternate Delegates:		
	2 years	Joseph R. Jehl, Passaic
	2 years	Emanuel M. Satulsky, Union
	2 years	Robert E. Verdou, Bergen
Delegates and Alternate Delegates to Other States:		
New York:		
Delegate	1 year	Albert F. Moriconi, Mercer
Alternate	1 year	Josiah C. McCracken, Jr., Atlantic
Connecticut:		
Delegate	1 year	Warren H. Knauer, Union
Alternate	1 year	Gastone A. Milano, Atlantic
Administrative Councils:		
Legislation		
1st District	3 years	John R. Tobey, Essex
2nd District	2 years	John J. Crosby, Jr., Hudson
3rd District	2 years	Leon A. Fraser, Mercer
4th District	3 years	Meyer L. Abrams, Burlington
Medical Services		
1st District	3 years	Joseph A. Lepree, Union
4th District	3 years	Robert S. Gamon, Jr., Camden
Mental Health		
1st District	3 years	Arnold M. Kallen, Essex
2nd District	3 years	Eugene V. Resnick, Bergen
Public Health		
1st District	3 years	George L. Erdman, Union
4th District	3 years	Frederick C. Steller, Monmouth
Public Relations		
1st District	3 years	Frank Y. Watson, Essex
2nd District	1 year	Frank R. Begen, Bergen
4th District	3 years	John P. Kengeter, Ocean
Standing Committees:		
Annual Meeting	3 years	James A. Rogers, Passaic
Finance and Budget	3 years	G. Thomas DeFusco, Hudson
Medical Defense and Insurance	3 years	Jesse Schulman, Ocean
Medical Education	3 years	Arthur Bernstein, Essex
Publication	3 years	Arthur Krosnick, Mercer
Woman's Auxiliary Advisory	3 years	Frederick W. Durham, Camden

* Nominated and elected by the House to fill unexpired term of James A. Rogers, M.D., who resigned upon being elected 2nd Vice President.



Dr. Rulon Rawson, Dean, CMDNJ at Newark.



Mr. John Kittredge, Chairman, Board of Trustees, CMDNJ.



Dr. Walter Schlesinger, Acting Dean, CMDNJ at Rutgers.

General Session Speakers—"Recent Developments and Current Status of CMDNJ."



Dr. Walter Schlesinger, Acting Dean, CMDNJ at Rutgers accepts AMA-ERE check from President Satulsky.



Dr. Rulon Rawson, Dean of Medicine, CMDNJ, accepts AMA-ERE check from President Satulsky.

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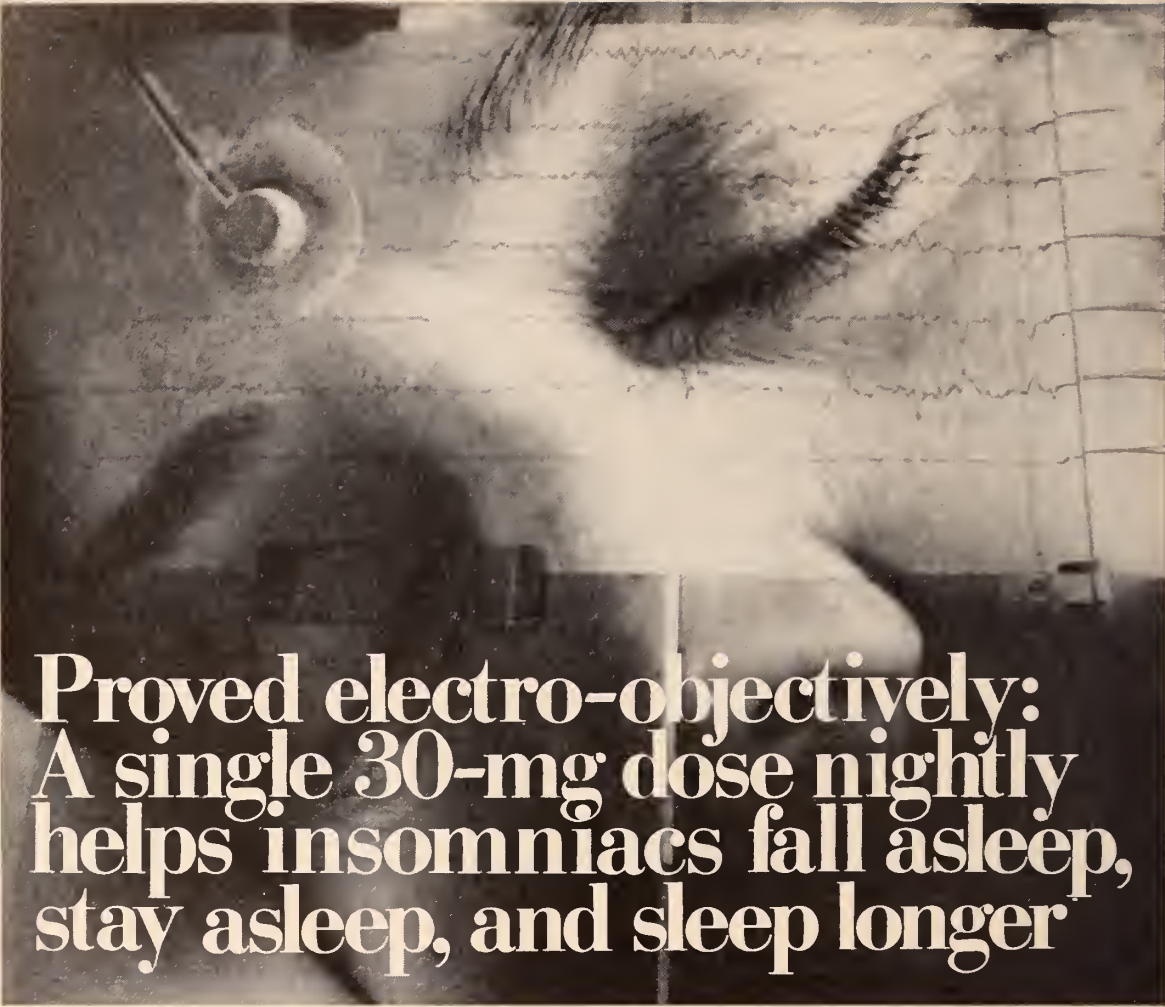
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- Fred G. Schwing, M.D., Physiatrist
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Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.^{1,2,3}

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,¹ Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

Confirmed clinically

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

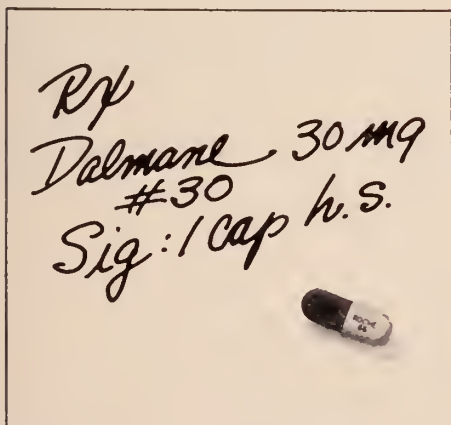
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.³ Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



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New **Dalmane**[®]
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Before prescribing, please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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Thanks to drug research and development, we've made substantial gains in the control of cardiovascular disease, diabetes, malaria, mental illness, strep and staph infections, meningitis and a long list of ailments. It seems like only yesterday when a diagnosis of pneumonia was almost the kiss of death. Now, with modern medical techniques and drug therapy, we can offer some real help.

My records on polio, influenza and measles show an unbelievable trend for the better. New vaccines

have reduced the toll of these age-old threats dramatically. And I see patients in pain from crippling arthritis helped with new medicinals unknown just a few years ago.

I hear questions about the three billion or so dollars spent by the drug industry in research during the past ten years . . . working on new and better drug products. It does seem like quite a bit of money to spend, and I realize some of it goes into dead ends. That's the problem with research, any research . . . you often don't know where you're going until you get there. I want all the tools I can get to help my patients. I want more drugs and more effective drugs. If they mean less pain, longer lives and more productive careers for those I treat . . . well, that's what really counts.

Another point of view . . .

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Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy; unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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Prescribing Information — Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and stotic foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
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Specific therapy for night leg cramps

GENERAL SESSION

Saturday Afternoon, May 15, 1971

The General Session was convened at 4 p.m., Emanuel M. Satulsky, M.D., President, presiding. Topic: "A Review and Report on Recent Developments and the Current Status of the College of Medicine and Dentistry of New Jersey." John K. Kittredge, Chairman, Board of Trustees, College of Medicine and Dentistry of New Jersey; Rulon W. Rawson, M.D., Dean of Medicine, College of Medicine and Dentistry of New Jersey; and R. Walter Schlesinger, M.D., Acting Dean of Medicine, Professor and Chairman, Department of Microbiology, Rutgers Medical School.

Dr. Satulsky: It is my privilege to introduce Rulon W. Rawson, M.D., Dean of Medicine, College of Medicine and Dentistry of New Jersey at Newark.

Dr. Rulon W. Rawson: I appreciate the invitation that you and the members of the Board have extended to us to discuss some of our problems and some of the advances that have been made. And there have, indeed, been many major advances made since a year ago, when I had an opportunity to report to you.

At that time, I noted that New Jersey's physician population ratio of 130 to 100,000 was significantly below the national average of 135 to 100,000. I explained that if we were going to bring our level of population ratio up to the average of the six neighboring states, we would need the fusion of 3,000 new physicians at that time. We foresaw a special replacement because one third of the physicians in our State are over the age of fifty-five; that we would have to bring into the State 300 new physicians per year over the next ten years.

Today I am happy to report that the two medical schools, in recognition of New Jersey's need for physician manpower, have responded by increasing the class size. This year, we will be accepting 110 students in our freshman class. This is a thirty-seven per cent increase over the class size of 1969. We will be able to make modest changes in our laboratories to accommodate these extra students.

Last year, we accepted (on a transfer basis) twelve New Jersey students who had completed a pre-clinical curriculum in foreign medical schools and had had very good academic records. They had all passed part one of the National Board examinations. This year, on the same basis, we will try to accept up to twenty-four American students who completed the pre-clinical curriculum in foreign medical schools. Again, we are looking for the natives of New Jersey.

The architectural plans that we designed for the medical center, the academic health science center in Newark, were designed to accommodate 112 medical students and eighty dental students. This is a significant increase over the number of students we had been teaching.

The fact that we recognize New Jersey's needs for more physicians has caused a degree of modest change in the building, which will make it possible to take care of providing programs for 112 dental students and 160 medical students. We have also recommended a modest increase in the size of the dental school, which makes it possible for the total dental curriculum, pre-clinical and clinical, to be taught in the dental school building. This will permit us to expand the laboratory spaces in our science building, so we can then accommodate 200 medical students and 130 dental students. Actually, this is a modest increase in the size of the building at a minimal cost, when one compares what it would cost to increase or build a new school to accommodate 130 students more than we had planned for in the original plans.

Studies have demonstrated that more than fifty per cent of United States physicians are practicing in communities where they have their in-hospital graduate or internship and residency programs. Let us look at internship programs in our State. There are 600 approved internships in New Jersey. In 1969, four per cent of these positions were filled by graduates from the United States medical schools. The next year, six per cent; this past

year, nine per cent. Most of those nine per cent came from our school in Newark. Let us ask why there are so few students matching here. Well, if one wants to attract quality or American graduates, we must provide a first-rate educational program in the hospital. Today's medical students recognize the importance of a strong graduate educational program. They look upon this as probably the most important period in preparing themselves for practice. Practically all graduate students are looking for internship-residency programs, which would give them the best preparation for the practice of medicine or for the practicing of a specialty and for specialty board accreditation. This is true in all specialties, including the new specialty of family practice.

The National internship matching plan was instituted in the late fifties. In 1958, forty-eight per cent of all the students applied for internship that year matched with major teaching hospitals, whereas 34 per cent matched with non-affiliated hospitals. In 1968, 58 per cent went to major teaching hospitals and 24 per cent matched with non-affiliated hospitals. In 1969 it was 63 per cent that went to your major teaching hospitals and 20 per cent to the non-affiliated hospitals. The Council of Medical Education of the A.M.A. and certain specialty boards have recently defined new guidelines for graduate medical education. Henceforth, internships will *not* be accredited, unless they are integrated into a full residency program. In 1975, those internships which have *not* been integrated in a full residency program will be phased out.

The Board of Examiners in Internal Medicine has recently established as a requirement that those hospitals having residency programs in internal medicine must have full-time Directors of Medicine.

The Liaison Committee, which periodically examines all U.S. medical schools for accreditation has, until recently, been composed of representatives from the Association of Amer-

ican Medical Colleges and from the Council on Medical Education of the A.M.A. This has now been expanded to include representatives of the new Council on Graduate Medical Education, which is sponsored by the specialty boards.

Medical schools being examined for accreditation in the future will also have their graduate programs or internship and residency programs in primary and affiliated hospitals examined.

Finally, the medical schools in the United States are accepting the responsibility for graduate education, which I believe they should have done a long time ago.

In recognizing the importance of developing strong hospital-based graduate educational programs, the College of Medicine and Dentistry in New Jersey has already established major affiliation agreements with three hospitals in Newark plus the East Orange Veterans' Administration Hospital, and is discussing affiliations with other hospitals in the region. Such affiliations have recently been recommended by the Carnegie Commission; and I urge that all of you read and study the Carnegie report on "Higher Education and the Nation's Health." This Commission, recognizing the importance of hospital-based graduate education programs to complement undergraduate medical education, recommended area or regional medical centers, which would be affiliated with the academic health science centers.

For New Jersey, the Carnegie Commission recommended the establishment of these academic health science centers and several area health science centers whose function would be as follows:

- (1) To maintain a community hospital of outstanding quality. Many of the patients would be admitted on a referral basis from smaller communities in the surrounding area.
- (2) To conduct educational programs under

the supervision of the faculty of the University Health Science Center with which the area center is affiliated.

(3) To have these educational programs include residency programs, clinical instructions for M.D. candidates and dentistry candidates who had come there from the University Health Science Center on a rotating basis.

(4) Clinical experience in allied health programs and continued educational programs for health manpower in the area, conducted in cooperation with the local professional societies.

(5) To provide comprehensive guidance at comprehensive colleges and community colleges in the area in the development of training programs for allied health professions.

I suggest that these proposals be examined jointly by representatives of The Medical Society of New Jersey, representatives from the New Jersey State Hospital Association, and representatives of the faculty and administration of the College of Medicine and Dentistry of New Jersey, with the objectives of establishing a network of health institutions to work cooperatively in developing strong graduate educational programs, which will attract well prepared medical graduates for internship-residency training in New Jersey.

Notwithstanding the many criticisms we hear from time to time directed at bio-medical research, I must state that a major responsibility of our faculties in medicine is to expand the body of knowledge in the bio-medical sciences. Unless we pursue the modern tools of study and imaginative research in cell biology, biochemical and physiological phenomena, and in human disease, we cannot expect to deliver better health care in the year 2000 than we delivered in the 1960's.

Many of us in this audience have had the opportunity to live through the most exciting period in medical history. We have observed the development of methods to control, treat,

or cure a great number of diseases, which, prior to 1940, had a high mortality or morbidity rate, such as pneumonia, rheumatic fever, tuberculosis, poliomyelitis, some congenital anomalies, and to effect the treatment, in some cases, such as some acute leukemias, to evaluate cardiac abnormalities, which could not be done prior to 1940, as it is done today, and to make certain the treatment is rational.

There remain many diseases which cannot be treated or controlled without expanding our basic bio-medical knowledge. These disorders include cancer, arteriosclerosis, hypertension, renal disease, arthritis, alcoholism, drug addiction, plus neurologic and psychiatric diseases. All these present us, as physicians, medical educators, and bio-medical scientists, opportunities for imaginative and productive research.

I call your attention to the major challenges and opportunities for innovative research in the delivery of health care. We, as physicians, medical educators, and health scientists, have the responsibility to seize these opportunities, and together, meet the challenges to improve the delivery of health care. Let us also enlist our colleagues in hospital administration, medical economics and health insurance, as well as consumers, in developing research programs in the delivery of sound, high quality health care for all society.

Thank you again for the opportunity to report to you on the activities of the Medical School in Newark. I look forward to a continued cooperative association with the officers of this Society and its component County Societies in meeting today New Jersey's challenging needs for medical education and better health.

Dr. Satulsky: And now I am privileged to introduce R. Walter Schlesinger, M.D., Acting Dean of Medicine, Professor and Chairman of the Department of Microbiology at Rutgers Medical School.

Dr. Schlesinger: Needless to say, any period

of transition and reorganization carries with it the excitement of challenge and opportunity, as well as the agony of uncertainty. I would rather not dwell on the agonies of uncertainty, but I must mention that within these past twelve months, Rutgers Medical School has lost fourteen faculty members, which constitute 22 per cent of its entire faculty, including four Department Chairmen, including all three Department Chairmen of clinical departments. This is only one of the difficulties we are facing.

It is my unique pleasure to acknowledge to you the sensitivity to the issues raised in New Jersey, and the total devotion to serve the State by the newly created Board of Trustees of the College of Medicine and Dentistry and by its Chairman, Mr. Kittredge.

The Board has worked very closely with the deans and faculties of the two medical schools and the dental school, and we have had the privilege of attending and being personally involved in said deliberations. This is all very good. It is to the credit of the Board and to the many friends of medical education in the State, including this Medical Society, that the College Board has resolved that there shall be parallel development of two complete medical schools in New Jersey, one at Newark and one at Rutgers in New Brunswick.

Concrete steps have been taken since then, but still great commitments will have to be made before both schools can produce the number of physicians which they ought to be capable of turning out. Dr. Rawson, myself, and our colleagues believe that New Jersey desperately needs at least three medical schools, and that ultimately some four to five hundred M.D.'s should graduate each year. Let us, by all means, develop to full capacity the two schools that we now have.

Where are we at Rutgers? Last summer, we moved into our new science building, as handsome and as functional in design as any medical school structure in this country. Total cost to the State was \$6,000,000. In this

building we accepted our fifth freshman class, increased from sixty to eighty.

The Psychiatric Institute is going up ahead of construction schedule, and we feel that the summer of 1972 will provide a home base for a first-class Department of Psychiatry, which has come together because they saw a hole in the ground and the building going up. It will also provide outstanding community psychiatric services with a classroom population of 200 plus.

The College of Medicine and Dentistry Board of Trustees has leased Raritan Valley Hospital, and architects are now designing alterations and additions that will make it into a useful mini-teaching hospital, while preserving its function as a primary care facility in New Jersey. Once modified and staffed, this 128 bed facility, providing affiliated services in obstetrics and gynecology and pediatrics, will offer primary clerkship opportunities for thirty-two students. We hope to be able to take that number of our present freshman class of eighty into the third year by 1972.

For the future we need more teaching beds and some of these needs will be met through the use of other hospitals currently under negotiations.

This brings me to the subject of teaching affiliations, which, by prearrangement with Dr. Rawson, I shall try to define, very briefly. The clinical education of a medical student can be divided roughly into four phases, each of which requires different kinds of teaching facilities. You doctors have all gone through at least three of them, but, perhaps, not the first one, which we regard as particularly important.

The first phase is emerging as the cornerstone, the pre-clinical learning stage, which is the first year of medical school. Today's student is increasingly motivated toward a social involvement and to early contact with patients, seeing them as an essential illustra-

tive counterpoint to his basic science instruction. Indeed, with the merging and ever-increasing rate of growth of medical sciences, it is not our intention to downgrade the so-called basic sciences, but rather to integrate them ever more closely with the total continuum of medical education for the clinical scientist. In this area of underpinning for the pre-clinical scientist, "correlation clinics" bring together clinical and pre-clinical teachers at an increasing level, either at the schools or in the hospitals, ambulatory or in-patient situations. For this, we have used already many of the area hospitals and physicians in our treatment.

Phase two consists of the traditional introductory course in clinical medicine, psychiatry, other specialties, and physical diagnosis. For these introductory courses, Rutgers Medical School has developed teaching units in some eleven community hospitals in Central Jersey, where members of the attending staff provide patients and time for instructions. These programs, expanding for this next year to eighty students are coordinated by Rutgers Department of Medicine.

Phase three consists of the primary clerkship program, the first days of the students in total and extended care of individual patients. We view this phase as the most crucial responsibility of a clinical teaching faculty, again with significant input by the complete medical faculty. Here, the student must work under the constant, around-the-clock supervision and guidance of experienced teacher-physicians, supported by the total intellectual and technical resources of the teaching institution.

We remain committed to the view that the primary clerkship phase must be conducted in the medical school base-teaching hospital, but can be extended to branch-teaching hospitals, major affiliates which have available the requisite manpower. This includes full time staff physicians, laboratory, and teaching facilities and programs to assure the same intense supervision that the university teaching hospital can offer.

The fourth phase is the advanced clerkship. Here we deal with the situation where the fourth-year medical student can bring something, other than just the load of intense teaching, to the community hospital; and it is our hope that we should be able to develop virtually every community hospital in the area of Central Jersey in the advanced clerkship program.

The opportunity of building a total State-supported medical educational program for seven and a half million is quite unique in the history of medical education in this country. New Jersey is the largest state, which, until recently, didn't have a single medical school.

We must emphasize flexibility. First of all, we want to attract to medicine the greatest variety possible of backgrounds in the pre-medical education of our students. This requires a highly flexible program of instruction. This will mean different kinds of curricula for different kinds of students. There must be flexibility in the time required from graduation of high school to the award of an M.D. Degree. We must allow for different area objectives of the students that come to us. We must, at the same time, preserve flexibility in the medical educational program in such a way that our medical schools can take fullest advantage of all the opportunities that emerge in support for different branches of bio-medical sciences and that health care provide.

For example, we are all familiar with the "conquest of cancer crusade" recently publicized. It was my good fortune recently to spend the last two days in Bethesda with the National Cancer Institute discussing ways in which this bonanza can be spent.

Our medical schools must have the base, both scientific, in terms of clinical facilities and manpower to take fullest advantage of this; and I aim to see to it that we do.

This means a solid base in research, to which Dr. Rawson has already referred. Look at the

exhibits right here during this Annual Meeting. These illustrate some of the ways in which research by the faculty and by the students has been put together. Some of the exhibits, in fact, are based entirely on the research competence and development of students and our faculty.

Shortly there will be submitted to the newly appointed President of the College of Medicine and Dentistry a program of medical education at Rutgers, which is strongly based on the assumption that our strong interaction with Rutgers will continue in such a way that we can pluck out of the University's pre-medical curricula (and also from the humanities students), at any time the faculty of medicine and the undergraduate faculties consider opportune, a man to enter medical school, which may be after the third year, and, in some instances, even earlier. We intend to propose that these students be given their pre-clinical material (those requiring laboratory instruction) in the first eleven-month period, and then go on to an integrated treatment of the clinical second year, and final year of advanced clerkship in the affiliated hospitals in the third year. Thus the time from high school to an M.D. Degree will be six years for the average student, rather than eight.

The close interaction between the medical school and university and other colleges in the State and out of the State remains essentially at the undergraduate level. We must think too of the medical educational level and of the level of graduate education, which uniquely is to prepare teachers of medical students and other essential elements in our bio-medical community.

So, this, briefly, is the plan that we will present. It is contingent on the creation of adequate teaching hospital facilities for the primary clerkship program.

Given an on-campus teaching hospital and appropriate affiliations to extend the competence of our teaching hospital with carefully

chosen community hospitals, we propose to increase our entering and graduating class to 160 per year. Do not be led into premature expectations by these numbers. One cannot evaluate physicians without the proper facilities, without the hospitals, without the outpatient facilities and all that. So, when we are talking in terms of these numbers, we are talking about six or seven years hence.

In the meantime, we hope to find adequate clinical training facilities for the eighty students who are now freshmen in the school, and for their successor groups of eighty incoming students.

I see almost a uni-sexual gathering in here; and I am happy to tell you that out of our eighty freshmen students, seventeen are women.

I think we have a rare opportunity to create an excellent medical educational system, but let us not put all the emphasis on quantity; let us keep the emphasis on quality.

Dr. Satulsky: Our next speaker is a distinguished citizen of New Jersey. He is Vice President and Actuary of the Prudential Insurance Company, an individual who has given of himself unselfishly concerning the problems of the medical school in New Jersey, Mr. John K. Kittredge, Chairman of the Board of Trustees of the College of Medicine and Dentistry of New Jersey.

Mr. John K. Kittredge: I was amused by the way, when I checked into the hotel, I was addressed as "Dr. Kittredge." When I came into the room I was addressed as "Dr. Kittredge." I am almost getting used to that now. It is a pleasure for me too, as a layman, to meet with so many distinguished doctors as there are here.

The Board of Trustees was formed in June 1970, as a result of legislation which formed an over-all Board, which supervised the then New Jersey College of Medicine and Dentistry and the Rutgers Medical School. The

Board started its work very rapidly after the legislation was signed into law, and we spent our early months learning about the mission of the college and trying to understand the issues.

There was an increase of the Rutgers entering class last September from 8 to 60. There was a change in the entering class at the Newark Medical School, which will admit 110 next September, compared to 85 last September. The Dental School in Jersey City will soon put into effect a three-year curriculum; and the net effect of this will mean that one full additional class of dentists will be graduated, compared to the situation that would have applied had the four-year curriculum been continued.

In December the Raritan Valley Hospital was acquired as an essential step toward the expansion of the Rutgers Medical School to a four-year school. At the same time (and several times during the year) the Board reaffirmed its determination to build a teaching hospital in Piscataway, adjacent to the Rutgers Medical School campus. This is an essential part of the proper expansion of the Rutgers Medical School to a very high quality, good, four-year medical school.

Another important step took place earlier this year, when the various problems, which were holding up the Newark construction plans, were resolved, and the power plant was put out to bids. Every member of the Board of Trustees is looking forward toward turning over that first shovel-full of dirt to get our program under way.

The power plant will be followed shortly, we hope, by the library and dental school in Newark, and then by the multiple sciences building. A bond issue is proposed for a referendum this fall, which includes \$50,000,000 for the multiple sciences building. The support of everyone here and everyone throughout the State will be helpful in getting that referendum approved, so that we can go ahead with the essential part of our construction program.

All in all, it has been a very busy year. For me, particularly, it has been a busy year since January, when Governor Cahill appointed me Chairman of the Board of Trustees.

There have been a number of other accomplishments and most of the credit is due to the hard work of the dedicated faculty and administration in Jersey City, Newark, and Piscataway; and contrary to rumors, we still do have a very fine faculty at Rutgers Medical School, and we, and the Board of Trustees, are very much looking forward to expanding it, to create a four-year school.

Last week, a major step was announced. We have been conducting a search, over several months, for a President of the over-all college, and last week we announced the appointment of Dr. Bergen as President of the College, effective July 1. Dr. Bergen is currently the Senior Vice President of the New York City Health and Hospital Corporation, a job which he has held since July of 1970. In Dr. Bergen, we believe we found an unusual, and, for us, fortunate blend of administrative ability and experience, academic ability, and experience with the development of community health care delivery systems.

The Board of Trustees was particularly impressed with Dr. Bergen's grasp of the issues, which was important to us, and his complete dedication to his work. We are all looking forward to his assuming the leadership of the college.

In short, the past year has been one of steady progress punctuated by crises. We sincerely hope the crises stage is fading away. A good measure of this may well have been the last Board meeting, which took place last Thursday, where we made good forward progress. I have to admit that I took a bit of personal pleasure from the fact that we had two reporters attending the public session and they went away disappointed because there were no newsworthy problems with which the Board was grappling, which they could report to their readership.

How does the Board of Trustees see its mission? We recognize that there are three traditional missions of the medical schools, which are, very briefly, education, research, and service.

Education is clearly viewed by the Board of Trustees as the primary mission of the college. Turning out a large number of high quality physicians and dentists is the greatest contribution we can make to medical and dental care in New Jersey. We are dedicated, as a Board, to the expansion of class size and facilities, but on a sound basis, one which produces high quality physicians and dentists. With the dedicated faculty we have much progress is being made and we expect much more will follow.

The Board has also a strong desire to expand to other locations within New Jersey. This is the one thing which we have had not much time to talk seriously about since we were formed because we have been struggling with various problems which have faced us.

We believe that it would be sound for us to expand to other locations, only after we have achieved a level of stability in our existing location; but, I am sure that other members of the Board will join me in hoping that we can start soon to study locations in the form of expansion to other areas of New Jersey.

I believe that research is essential to the conduct of the medical school. The most obvious reason is the value of the research, itself; and we must do our part if we are to participate in the improvement of medical care in the United States and New Jersey generally. That is the most obvious reason, but there are others. Thus, research is a part of the educational process. We are particularly proud of our summer program in Newark, in which we expect 85 students to participate this year. There is a similar program for summer participation in research at Rutgers. There are exhibits in the exhibit hall from both schools which are partly a result of the summer programs. This research program helps

us to aid in the development of these students into good doctors. Also, remember that research is needed to attract good faculty. Most of the faculty we want are individuals who insist upon the challenge of research and we must give them the opportunity to do that. In short, research is an essential part of the college's program. As a layman, I don't pretend to understand the significance of all of the research which is conducted by the college—I must leave that to Drs. Rawson and Schlesinger—but it is not difficult for me to recognize the relevance of much of the research conducted by the college to the specific problems of New Jersey and the nation. Here again, there is another exhibit in the exhibit hall, which illustrates some of the problems of lead poisoning in Newark; and, certainly, this is a relevant problem for research.

A third area of the college mission is service; and the most obvious part that the college plays in the delivery of service is the running of Martland Hospital in Newark. The college staff has done an admirable job of raising the quality of care at Martland Hospital since assuming responsibility for the hospital in 1968. However, we all recognize that there is much to be done, and we are dedicated to that urgent task. The college also plays an important role in providing community service in many other important ways, and we expect that it will continue to do so.

Physicians tend to practice where they interned and had their residency programs. As Dr. Rawson has illustrated, New Jersey's experience has been particularly poor in attracting interns and residents. One bright note was the selection recently of Martland Hospital by thirty-three of our 1971 graduates for internship. This is a startling increase from nine in 1970, but it is not really enough to just attract interns to Martland Hospital. It is essential that interns be attracted to other hospitals in New Jersey and this is an area where we must all work together. I urge all of you to take whatever steps you can toward this objective; only in this way will the educational efforts of the college produce the im-

portant results we all want of increasing the number of physicians in private practice in New Jersey.

The college has been through many difficult years. When I, fairly recently involved in medical education, look back at the history, I marvel at how those who have guided the college have made so much progress against so much adversity.

I would like particularly to point out the tremendous contribution made toward this progress by Dr. Robert Cadmus, who will relinquish his presidency of the Newark center on July 1. His efforts over the past several years have been crucial to the survival and progress of the New Jersey College of Medicine and Dentistry, which is now a major part of our college.

I would also like to point out the essential contribution made to medical education in New Jersey by those who were responsible for starting the Rutgers Medical School and nurturing it through its early years. Specifically, Dr. Mason Gross, who will relinquish the Presidency of Rutgers University this summer, and Dr. Stettin, who was the dean of that school from its founding until about a year ago.

Although we have been plagued with many problems, I, personally, am optimistic, and I know that the other Board members are also. I am confident that the already steady growth will accelerate. I believe we are now entering a period when we can anticipate and act, rather than dissipate so much of our energy in reacting to problems which are thrust upon us.

In fact, those in New Jersey who are really interested in the progress of medical education can best do this through their support of the college's activities and through constructive criticism.

You have working for you a dedicated and able faculty and administration, and a hard-

working and involved board, which sincerely want to make significant progress. With your help and the help of others in New Jersey, I feel sure we will have medical and dental schools which are truly outstanding.

Dr. Satulsky: Ladies and gentlemen, I think when the Board of Trustees decided to present this general session, entitling it "Recent Developments and Current Status of the College of Medicine and Dentistry of New Jersey," it selected three people—Dr. Rawson, Dr. Schlesinger and Mr. Kittredge—who certainly have given you a bird's-eye view of the present status of medical education in medical schools today.

Are there any questions?

Dr. Schauer: (Monmouth) I would like to thank Dr. Rawson. When he came to speak at the Monmouth Medical Society meeting, unfortunately, I, very rapidly, developed laryngitis that night and I couldn't even speak to thank him, at the end of the meeting. So, I will take this opportunity to thank him for coming down and speaking at Monmouth, at that time.

I would like to have a little more explanation, or information in view, particularly, of what Dean Schlesinger said, that we are on the threshold of doing great things in our State, and we have the opportunity to make our State unique or great in the development of the medical schools, and perhaps in the development of better physicians. Well, I would like to know the present status and some of the thoughts, with reference to Family or General Practice Department. I am a family physician or general practitioner—and I am proud of it—and I think it is an important part of medicine, and I think it is coming to the foreground. I appreciate the comments with reference to medical research, and I have already seen some of the exhibits that the students are doing, and I do not wish to downgrade this. I appreciate what Dr. Rawson told us when he came to Monmouth County, that medical research stimulates the

student, makes him a better student, and, therefore, a better physician. But I also maintain that more attention should be paid to producing another type of physician, namely the family doctor. I would like to know your thoughts with reference to this.

Dr. Rawson: We do not have a Department of Family Practice or General Practice. As I understand it, family practice of medicine does call for a concentration in internal medicine, pediatrics, and certainly a lot of know-how in the field of psychiatry, and perhaps some minor obstetrics and some minor surgery.

Our school has Departments of Medicine, of Pediatrics, of Surgery, of Psychiatry, and of Public Health and Preventive Medicine. Students make their decision as to what field they are going to pursue or specialize in on completion of their education. Usually they choose their internships or make their decision on internships in the late fall or early winter of the fourth year of medical school. They make their decisions, I believe, as to whether they will do family practice or specialty practice, usually during their first year of graduate training.

I agree, there is a need for more primary physicians. I do not believe that a one-year rotating internship is enough for them. Indeed, the family practice groups did decide that they need three years of preparation for that.

There are also a number of people trained in internal medicine, who go into family practice. There are opportunities now to take training in internal medicine and in pediatrics for those who wish to be primary physicians.

I would not agree with you that students should not have an exposure to research. I think medicine is problem solving; and no matter whether you see a patient with a sore throat, which may be a simple viral infection, or whether you see a patient with a very

complicated exotic type of disease, no matter what you do with the patient, you are doing problem solving. I favor the exposure of the student to some investigative problem, whether the problem be in the clinic, whether it be done in the community health program, or whether it be done in a bio-chemistry laboratory. It is teaching him something about problem solving and being critical in his evaluation. I would say that this type of program is as important as any other part of the curriculum.

Dr. Schlesinger: Although we are not yet in the situation where we can very significantly help the student make the right decision because of our being a two-year school, I do want to throw on the table one point on which I hold very firm conviction.

There is that one element so crucial to any educational task that has been sadly lacking in medical schools in this country particularly. It is something that can be summarized in one brief word: pedagogy. We haven't had pedagogy. Pedagogy sets up the right kind of motivation that enables the future physician to function in that societal setting that ultimately he finds himself. Beyond the creation of the right attitude, there is relatively little play that medical schools have in the short span of three or four years in which they can modulate the curriculum very much. There is very little in the curriculum that we can throw out and very little that we can add on to it without expanding the time limit.

So, let me suggest the kind of attitude that will lead the young physicians into the primary or general practice of medicine, into the family practice. This is set by the faculty, yes, but also by the environment in which he has either his primary or secondary clerkship and his internship. We will do everything we can to encourage students to keep all their options open until the moment of decision-making is there.

Dr. Abrams: (Burlington) The State Society has, on a number of previous occasions, urged the concept of building a third medical

school in the South Jersey area. Dr. Frank Hughes has chaired a commission to do a survey on the South Jersey area, and it was found to be indicated in this area.

Dr. Schlesinger has made reference to the fact that this is one of the ideas—to have a third medical school, although he didn't state where—and I would like to know what is being done or what has been done toward fostering construction of a third medical school in the South Jersey area preferably?

Mr. Kittredge: The Board of Trustees recognizes the need to expand, and the southern part of New Jersey is a logical spot for expansion. But we have been spending the last year trying to get under control, from our viewpoint, and trying to move ahead positively on the two or three schools which we do have, the two medical schools and one dental school. We would be doing an injustice to any third school which we started to develop, at this point, if we tried to do it before the further development of the two schools which we now have—two medical schools which we now have.

Dr. Abrams: (Burlington) What are we talking about in terms of time before we might consider the building of a third school; and bear in mind also that I think a school can be well used now in South Jersey, and planning takes a long period of time, and so does construction; and planning, I think, in itself, costs a lot less than construction? In the effort to save time in bringing a medical school to South Jersey at the earliest possible time, planning should have been started already. Something ought to be done along those lines, and something should have been done along those lines, and isn't it a question of when.

Mr. Kittredge: I can assure you, in our time frame, we have a much greater sense of urgency than "some day."

Now that we have a President for the over-all college, we are going to have to be guided as much by his advice and that of the deans

because even though the deans are at specific locations, we will have to draw from their resources in doing this planning.

Dr. Ponce: (Essex) Dr. Rawson, you mentioned 200 students per class, and I didn't get your target date for achieving that.

Dr. Rawson: Our target date for achieving that—for the 160 students—is when we can move into the presently planned building with the minor modifications we have made in those plans. We will be able to accommodate up to 160 students.

I made the statement that if we can—and we have practically made the recommendation—that there be a minor addition to the building plan (which will permit the total dental curriculum being taught in the dental school) in expanding our basic science program of the medical school in the area that the dental students will now be using—with that we would be able to accommodate 200 students. I don't foresee our being able to even accommodate 160 students per class, prior to 1975 because I think it will take that long to complete the building.

Dr. Ponce: (Essex) Does the Board of Trustees consult and pay particular attention to the feelings of the faculty in the choice of the new President?

Mr. Kittredge: There was a Research Committee of the Board of Trustees appointed; and to assist that Research Committee there was also an Advisory Committee which was composed of two faculty members, one of them also represented the alumni, and one student from the Newark Center, and two faculty members and one student from the Rutgers Center. This Advisory group participated fully in the discussions of the Research Committee, up to, but, of course, not including final decision by the Board of Trustees. We attempted to get as much input from the faculties, as possible.

Dr. Ponce: (Essex) You say we are mainly

interested in quality, yet there is a determined attempt to shorten the curriculum. I can see you have emphasized ways in which one can accomplish this at the medical school level, but you are also talking about taking them out of college earlier and earlier. Are you giving adequate attention to the fact that these men will have adequate training in the humanities?

Dr. Schlesinger: Thank you for asking that.

I would hope that the pre-medical preparation, working in consultation with us, would, indeed, emphasize the humanities and the social studies, and would free us of a student body of whom an increasing number have "already had it."

I put it in quotes because the fact is that while they have had a great many courses in bio-chemistry, and all the rest of them, they have not had them in such a way that the student, himself, can easily make the application of the human subject in health or disease. Our pre-medical departments—and I can speak with feeling; I am the Chairman of one of them—do have to engage in a program which appears to involve a fair amount of redundancy in the view of the student. It is my hope that by working closely with the undergraduate faculties, especially in our situation in New Brunswick, we might be able to eliminate from the pre-medical curriculum some of these specialized courses and, perhaps, ultimately involve members of those departments to help us in the teaching of the very vastly increased number of students in the medical schools.

It is our conviction that it is the faculty of medicine which is uniquely qualified to teach, for example, organic or physical chemistry, those elements that are of particular importance for a medical student or physician to know.

So, it is at that level that we do not want to cut off any of the humanities or any of the social studies. We need them all.

Dr. Collins: Now, where are the students going to be exposed to pedagogy when there is no Department of Family Practice? No one is speaking for family practice, it is just a university-affiliated medical school. If you don't have a Department of Family Practice, it is still going to be fragmented in internal medicine, pediatrics, a little surgery, and so on.

Dr. Satulsky: I think that was a statement, Dr. Collins, more than a question.

Dr. Grimes: (Camden) Realizing, of course, the realities of the delay in establishing a South Jersey Medical School, I would just wonder whether Dr. Schlesinger would be interested in considering the question of preceptors in South Jersey.

Going back to my medical school days at Tufts thirty years ago, I was sent out on preceptorships to Western Massachusetts, down to Rhode Island on two separate occasions, and I look back to those teaching experiences with a great deal of fondness and a strong feeling that I got a great deal out of it.

We have a vast teaching potential in South Jersey. Many of us are teaching in Philadelphia. I am currently teaching at Penn. I will be perfectly happy to take a couple of preceptors—preceptees, and the whole South Jersey area is full of aspiring preceptors, which I think would be offered.

Knowing that it takes ten years, for example, to develop an area to put a steel plant in, it might be a good thought to put some feelers down into places such as Tufts, all the way down through New England, with a great deal of fruition. And I was just wondering if it is being considered.

Dr. Schlesinger: I think this is certainly being considered. I would not want to put a geographical limit on anything. At this point, unfortunately, we are still talking in theory because we don't have a current program going yet. It will be going, and then that will cer-

tainly be very seriously considered and we will talk about it.

I have been in contact with people in the Camden area, not very sensitively, but I think we can see the vast opportunities.

Dr. Smith: (Burlington) There was a mention that nothing very much can be added to the curriculum and very little can be taken out of the curriculum. I would like to suggest three points to consider very seriously in the addition to your curriculum. In our day, we were totally ignorant of medical and social economics, a very important and vital part of the training of any individual, particularly a physician. Then there is the area of teaching them medical administrative efforts; and if we do decrease the earlier years, the pre-graduate school years, there will be less time for them to just grow up in and to achieve this kind of administrative ability; and if, in fact, eventually health teams are going to be necessary to deliver proper health care services, these physicians, who will require probably the longest period of training professionally, will hopefully be asked and looked to to be the leaders of such teams or help them in leadership.

So, administrative abilities are important and should not be overlooked and can be ground in, if you will, into such a curriculum.

The same health care teams will be involved in ongoing teaching programs in the medical student's curriculum, in the nurse's curriculum, and in the allied health personnel curriculum. They should be blending together because they are going to be working together.

I hope these things are being considered in the beautiful new dawn of development of the medical school in your area.

You spoke of branch teaching hospitals. I think this is the only realistic way you are

going to get your students to go out into the field, so to speak. I hope the Newark division doesn't expect to obtain all of their training and clinical experience at Martland. They are going to have to get outside of the ghetto, urban area and go into the community hospitals adjacent to your Newark area.

I would like to make this suggestion for you to consider; and I hope that Mr. Kittredge is thinking seriously because I believe firmly that the Board of Directors' responsibility is to get involved in the curriculum, despite the fact that they are not medical educators.

In answer to the branch teaching, you are not going to be able to create full time medical teaching staffs at all your branch hospitals. A more realistic approach would be to have, perhaps, a full time coordinator, and your teaching is going to be by the many family practitioners; and the specialist who works there in private practice will not be able to give full time; and you don't have enough men, at this point in time, to recruit full time teaching-type of individuals in community hospitals.

Please don't wait for the time when you will get these full-time men in the branch offices, so to speak. Use the men who are there and are practicing daily, who can give you part of their time, and will love to do it because it helps them keep their educational level going on all the time because when you get a smart question, you have got to have a smart answer.

Dr. Satulsky: Thank you, Dr. Smith.

Mr. Kittredge, Dr. Schlesinger, Dr. Rawson, you have earned the respect and admiration and thanks to The Medical Society of New Jersey; and I thank you for participating in this panel. I think we have had an outstanding session, and I want to thank you for your questions.

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Dr. Edward C. Senay is the Director of Clinical Research for the Illinois Drug Abuse Program and Associate Professor of Psychiatry at the University of Chicago School of Medicine, Chicago, Illinois.

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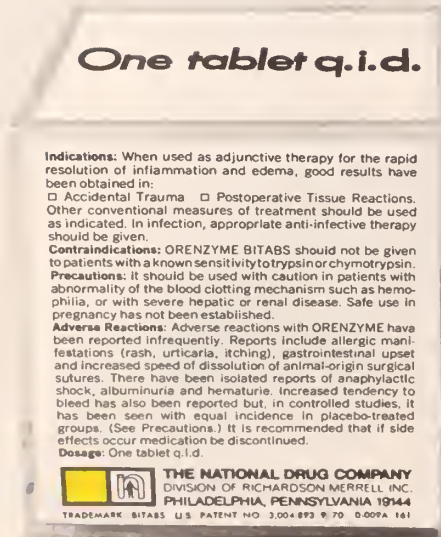


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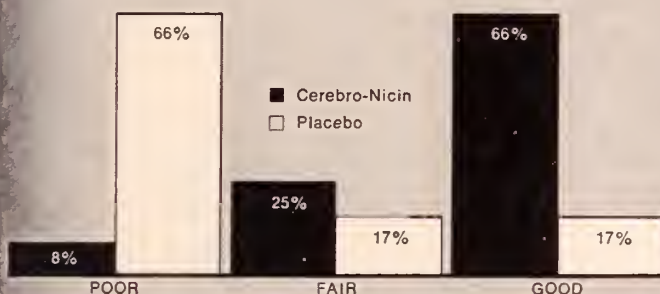
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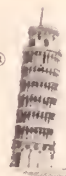
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DINNER DANCE

Mr. Richard I. Nevin, Toastmaster.

Mr. Nevin: Ladies and gentlemen, welcome to another Presidential Dinner.

Dr. Satulsky has requested that I say Grace with you.

I think even God will understand if you want to stay in your places and be properly devout. Saint Ignatius used to say that you can pray best in the most relaxed position. So turn your thoughts heavenward, remain seated, and pray.

Almighty God and Father of us all, be Thou in our midst and in our hearts. Help us to manifest Thy loving presence by the goodness of our lives and the worthiness of our actions.

Bless our guests of honor here tonight and bless us, O Lord, and these Thy gifts, which we are about to receive from Thy bounty. Amen.

Now, I invite Mrs. Alexander Bertland, President of the Woman's Auxiliary, to bid you welcome.

Mrs. Bertland: Dr. Satulsky, friends, it is my happy privilege to welcome you to this dinner-dance in honor of Dr. Satulsky. Have a wonderful evening, kick up your heels, and have fun.

Mr. Nevin: Ladies and gentlemen, while the photographers are putting on this floor show, I hope you won't mind if I introduce the guests at the head table or people at the head table and some of our guests to you, so that when the entree comes you can give it your undivided attention.

(Introduction of guests)

Mr. Nevin: Ladies and gentlemen, for years, now, it has been my privilege, in furtherance of my service to the Society, to trudge an uphill road with Manny Satulsky. As Robert Burns puts it, "We clamb the hill together."

Tonight, we pause briefly at the summit, not for a final summit conference, but for a brief moment of parting.

The walk with Dr. Satulsky has been an exciting and satisfying experience. There are few areas of programs and concepts that we have not together explored. Our findings were variable, but I think he will agree that we were amazed at times at the inherent unsoundness and instability of some of the proposals we looked into.

It seems to me, we were like the young couple who were being shown about by a real estate agent because they were interested in buying a home. He took them, first, to a very ramshackle place, which because of neglect and the elements, had very badly deteriorated, but this was about the bottom of the scale of available properties, and he wanted them to know what the market was like.

The young man looking at this wreck of a house said to the real estate agent, "Well, what's keeping it up," and the reply was, "Shhhh! All the termites are holding hands!" (Laughter)

Concerning some of the proposals and programs we investigated, we wondered if the termites might let go. Even some simple terms and ideas can prove confusing and embarrassing.

One that suggests itself to me is the term, "peer review." It is posing some concern to the House of Delegates. The misunderstandings which it seems occasionally to engender reminded me of a story that I heard that centers at the Waldorf-Astoria at the turn of the century. It concerns itself with an outstanding member of the English aristocracy, who came to this country and engaged a suite at the Waldorf, in advance. After he had been installed, he called down angrily to the manager. When the manager arrived, the English lord greeted him and said, "I have never been so insulted in my life."

The manager said, "What do you mean?"

He said, "Follow me, please, through the living room and into my bedroom."

There, around the bed was a whole series of about twenty-five or twenty-four of what they then called alabaster chamber vessels.

"Now," the lord said, "Now, what is the meaning of this insult?"

The manager said, "I have no idea, but I will call the maid in charge of the room and see if she can explain it."

So, he called her in and said to her, "Bridget, can you account for these chamber vessels around his lordship's bed?"

She said, "Of course, I can."

He said, "Did you mean to be insulting to his lordship?"

She said, "Of course not."

He said, "Well, what was your intent?"

She said, "I am concerned to accommodate him."

He said, "Accommodate him, in what respect?"

She said, "Did you not tell me, he is the biggest pe-er in England?" (Laughter)

I want to take this opportunity to thank Manny for the satisfactions of the year and to express for him my affectionate regard. He is dynamic, aggressive, forthright, and wholly earnest. At all times, he gave to the tasks of the presidency his generous best, with what gratifying results the record of the year eloquently discloses.

Now, he is to divest himself of the challenging mantle of the presidency, and to be vested as a Fellow of The Medical Society of New Jersey for all times.

Here to accomplish the change is Dr. Nich-

olas Bertha, who, himself went through the same ritual only last year.

Dr. Bertha: Will the following gentlemen please come to the front, to the podium: Dr. Bedrick, Dr. Calvin, Dr. Collins, Dr. McCall, Dr. Kustrup, Dr. Kaufman and Dr. Jehl. These are the Fellows of The Medical Society of the State of New Jersey, who are present at this meeting.

Gentlemen, it is the wish of the outgoing President that I shall pass this key to you, and that each of you, in turn, shall pass it to the one next to you, and you will finally return it to me.

Dr. Emanuel Satulsky, you have reached the summit, but now you are going to skid. My dear friend Manny, before we present you your key, may I say a few words to you.

Quoting from Edwin Markham: "There is a destiny that makes us brothers; none goes his way alone. All we send into the lives of others comes back into our own."

This quotation is so apropos for you.

You and I have been together for many years. We have learned to live together and share our responsibilities. All this did not occur as a result of chance, but as a result of hard work and dedication. Certainly, there were occasions when there were difficulties, some friction and varied reactions when we had to adjust to something new. Sometimes you won, sometimes I did.

I believe we were quite successful in adapting ourselves to these problems. Part of the reason for this adaptability is the fact that I believe the both of us, but particularly you, have followed the definition of youth, as stated by Samuel Alman: "Youth is not a time of life; it is a state of mind. It is not a matter of ripe cheeks, red lips and supple knees. It is the temper of the will, of quality of the imagination, a vigor of the emotions. It is a freshness of the deep spring of life. Youth means a temperamental predominance

of courage over timidity; of the appetite of adventure over other needs.

"This often exists in a man of fifty, more than a boy of twenty. Nobody grows old by merely living a number of years. People grow old only by deserting their ideals. Years wrinkle the skin, but to give up enthusiasm wrinkles the soul.

"Speaking of courage, it doesn't take courage to go along with the crowd, but it takes courage to be independent; to use your head when the loudmouths are insisting that you do something that you know in your bones is wrong. It takes courage to exhibit good sense when the foolish around you are insisting that you behave as stupidly as they. It takes courage to meet such a test of character head on."

Manny, you have always been such an individual as I have described. You have had courage in performing your duties and you have had patience in your adversity. Now, may God grant you comfort in your home, happiness in your leisure, success in your further ventures, and safety on your journey. With this key, Manny, I welcome you to the Club.

Dr. Satulsky: Thank you, Nick. Lou, Joe, John, Jesse, John, Jerry, Charlie, you know how much I love you; and I hope you understand when I say that nothing could have given me greater pleasure than to receive this pin from your hands and from the hands of my dear friend, Nick Bertha.

I have given this job all I have got. I hope I have pleased you all. Thank you very much.

Mr. Nevin: Now, ladies and gentlemen, Dr. Satulsky will present to Mrs. Bertland her Fellowette Key as she retires as President of the Woman's Auxiliary of the Medical Society of New Jersey.

Dr. Satulsky: Thank you, Mr. Nevin. Of course, I am in a peculiar position here be-

cause I remember several years ago, when the last Fellow of the Union County Medical Society, Dr. Louis Wegryn, pinned this pin on the outgoing Fellowette, she squealed, why I don't know. Tonight I am not taking any chance, and I am not going to die on this platform as the outgoing President. I understand that Mrs. Bertland has the most jealous husband in the history of The Medical Society of New Jersey, and before I pin the pin on her, I am going to insist that he stand up here alongside of her and assist me.

Mr. Nevin: With all the missions accomplished and no disastrous results, it is now my pleasure to call on Dr. Henry Mineur, President of the Union County Medical Society, to make a presentation.

Dr. Mineur: I am here on behalf of the membership of the Union County Medical Society to make a presentation to its most distinguished member.

What do you give a man to express the affection that you feel for him? What do you give him that will signify the great honor that you feel to have been associated with him? What do you do to demonstrate the tremendous respect that you feel for him, and the great gratitude that you feel for the fervor and zeal with which he has carried on the activities of the past year? How can you give him something that might connote the wishes that you have for his happiness in the future?

We have a token to present that, we hope, will signify this to Manny in the future, and I would say that I hope that we might make a blend, as you would a blend of tobacco, blending affection, honor, respect, gratitude, and many wishes for happiness for the future. And, Manny, you take that and you put it in your pipe and smoke it.

Dr. Satulsky: Thank you, Henry. I will open it, but before I do, members of The Medical Society of New Jersey, Union County, stand up and be counted. Thank you very much.

Mr. Nevin: Because the entertainment which is to follow—the excerpts from the “Student Prince”—will be presented by the Scotch Plains Players, who are closely identified with Union County, I have asked Dr. Mineur to serve as the Master of Ceremonies and to introduce the entertainers and the entertainment.

Dr. Mineur: The Scotch Plains Players, that are here this evening, are an amateur group who were organized about nine years ago, and they are here under the aegis of one of our great producer-writers, entrepreneurs, Howard Lehr, who also arranged for the entertainment Saturday night.

They put on the “Student Prince” a couple of weeks ago, and what they have done is to

truncate the version; I believe it will run about forty-five minutes. It is the old beautiful music.

I have kind of a vicarious pride in this. I might claim to be a co-producer with my wife, although she did all the labor involved. You see, the girl singing the lead is our daughter. This is purely coincidental. I had nothing to do with her being here.

Now, while they are setting up the chairs, since they will be dancing and singing from the stage, I might suggest that if any of you wish to, you might move your chairs out of the corner on to the floor, if you wish. How the acoustics will be, we don't know; we have not tested out the theater yet. Since Dr. Lehr says we are ready, let the show begin.



Immediate Past-President Bertha Presents Fellow's Key to President Satulsky.



President Satulsky Accepts Fellow's Key.



Richard I. Nevin, Toastmaster.

THE AUXILIARY YEAR—1970-71

Saturday Afternoon, May 15, 1971

Mrs. Alexander Bertland: Dr. Satulsky, Mr. Speaker, Members of the House of Delegates. The theme of the Woman's Auxiliary to the Medical Society of New Jersey this past year has been Accent on You—Be Alert, Be Informed, Be Involved at the grass roots level where the need exists and where auxiliary members may be of help.

This theme has been the story of the activities of the twenty-one component county auxiliaries in community health, in problems of children and youth, in the recruitment of our young people in paramedical careers. There has been an increasing awareness and concern with the problems of youth—especially in drug abuse and the underlying causes. Our programs have been planned to inform our members about community problems, what is being done to combat these problems, and how we may be of help. All this is with the prior approval of our county medical societies. Our program speakers have been members of our county medical societies, experts in drug abuse programs, mayors, civic leaders, county and state legislators, and county health coordinators. At the urging of our state chairman of children and youth, we have taken field trips to drug rehabilitation centers, day care centers, homes for our troubled teenagers. We hope that we have been able to promote good public relations for our medical societies in our own communities. Where we have not been able to help directly with volunteer service, we have provided funds for furnishing these centers, for expanding these programs.

One of the most outstanding county activities this year was the 44th Annual Health Education Day sponsored by one of our larger counties. The panelists were experts in the

field of pediatrics and drug abuse. A professor of clinical neurology cautioned that we have established, wrongly, criteria which we call "normal" for our school children, that we must increase the quality of life and the opportunities for our students to find challenges which they can meet. Camden County's answer dealt with that county's efforts to combat drug abuse. Representatives from civic and health organizations, and interested students were invited to attend. We came away realizing the need for communication with our youth. Besides the panel discussions, literature was made available on health careers and problems.

One of the smaller counties has promoted a county-wide pre-school screening program for amblyopia through the cooperation of the New Jersey Commission for the Blind. Auxiliary members served as volunteer workers at each of the five test centers in the county. This small auxiliary has underwritten the cost of the testing. Even more important, it has taken steps to urge school authorities to make this testing mandatory for school registration. Our newest county, Sussex, responded to a call from its medical society to help with a much-needed blood donor program in Sussex County.

Our auxiliaries have provided hospitality for our young foreign interns and their families, and have included the wives of these young physicians at auxiliary functions. One county auxiliary helped organize an international club at a community hospital and provided refreshments for club meetings. The young foreign interns in turn showed slides, discussed foods, customs, and health problems in their countries.

This year, at your request, we have made the Medical Society's Medical Student Loan Fund our top priority. To date, we have contributed \$4,745 to this fund, with several large contributions yet to be sent in. In national priorities, we have also contributed to AMA-ERF. Our total contribution to AMA-ERF this year has been \$6,382. You will hear from Dr. Satulsky how these monies have

been returned to our state in the form of national grants.

This year our total membership is 2,519, six fewer than last year. One of our county presidents reported that her auxiliary was having "menopausal syndrome," that fund raising was becoming burdensome, and that the younger wives were not interested in group activities of the county auxiliary. We have tried to enroll all potential members into our county auxiliaries. We hope that county medical society members will encourage your wives to become active auxiliary members. One of the most successful joint county auxiliary and medical society affairs this year was held in Morris County, with the wives arranging for an international buffet supper to honor an outstanding county physician. The good fellowship this affair generated was tremendous!

We try to promote good rapport with other organizations such as the American Association of Medical Assistants. Some of your medical assistants have become members, in this effort

better to serve the medical profession, and many physicians have paid the cost of testing to become eligible for certification. One of the most cordial receptions this president received was at the Annual Awards luncheon of this organization held recently in Atlantic City.

We have been big sisters to the young wives of medical students, better known as WA/SAMA to develop an interest early in their professional lives in auxiliary objectives.

We truly have tried to be alert, informed, and involved. We are always ready and willing to serve the medical society. Don't ever underestimate the power of a woman! And now, let me express the appreciation of our county and state woman's auxiliaries for serving as our advisers and for your support and interest in our activities throughout the year. It has been a privilege and honor for me to have served as president of the Woman's Auxiliary to The Medical Society of New Jersey this past year—the highest honor which may be bestowed on a physician's wife in our state auxiliary.



Auxiliary President, Mrs. Bertland, Reports to House.



Mrs. Bertland Receives Fellowettes Pin from President Satulsky.

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ATTENDANCE

REGISTRATION OF HOUSE OF DELEGATES

Registration:

Total Possible—Officers and Fellows	24
Total Possible—County Delegates	364
Total Possible—1971 House of Delegates	388
Total Registered	361

Attendance of County Delegates at the House Sessions:

1st Session, 5/15/71	314
2nd Session, 5/16/71	333
3rd Session, 5/18/71 A.M.	324
P.M.	293
Average	316

Official Attendance Report

County	Delegates	Members	Total
Atlantic	8	45	53
Bergen	40	30	70
Burlington	9	18	27
Camden	21	36	57
Cape May	2	5	7
Cumberland	4	10	14
Essex	69	105	174
Gloucester	4	13	17
Hudson	28	21	49
Hunterdon	1	1	2
Mercer	24	27	51
Middlesex	18	21	39
Monmouth	20	36	56
Morris	19	30	49
Ocean	3	12	15
Passaic	29	38	67
Salem	3	8	11
Somerset	5	6	11
Sussex	3	3	6
Union	29	42	71
Warren	3	6	9
Fellows and Officers	19	—	19
	361	513	874

Physician Guests	72
Physician Exhibitors	20

TOTAL PHYSICIAN REGISTRATION 966

Auxiliary	343
Visitors	376
Exhibitors	221

TOTAL REGISTRATION 1,906

FIVE YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1971	966	940	1,906
1970	989	1,104	2,093
1969	1,041	1,073	2,114
1968	1,112	1,176	2,288
1967	1,017	1,018	2,035

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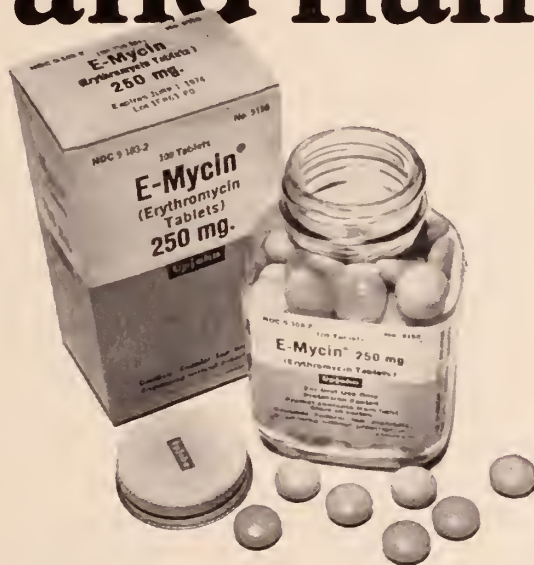
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The opening session is set for Wednesday, October 6, 1971. IF YOU ARE INTERESTED IN ENROLLING AND HAVE NOT RECEIVED AN APPLICATION FORM IT IS IMPORTANT THAT YOU WRITE IMMEDIATELY TO THE CHAIRMAN OF THE COURSE, DR. S.E. MOOLTEN, MIDDLESEX GENERAL HOSPITAL, NEW BRUNSWICK, N.J. The fee for the entire Course (34 sessions) is \$175 (for members of either Academy the fee is \$160; for interns and residents \$45).

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating ma-

chinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impend-

ing depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG pattern (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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JOURNAL

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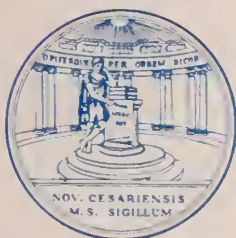
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AUGUST, 1971
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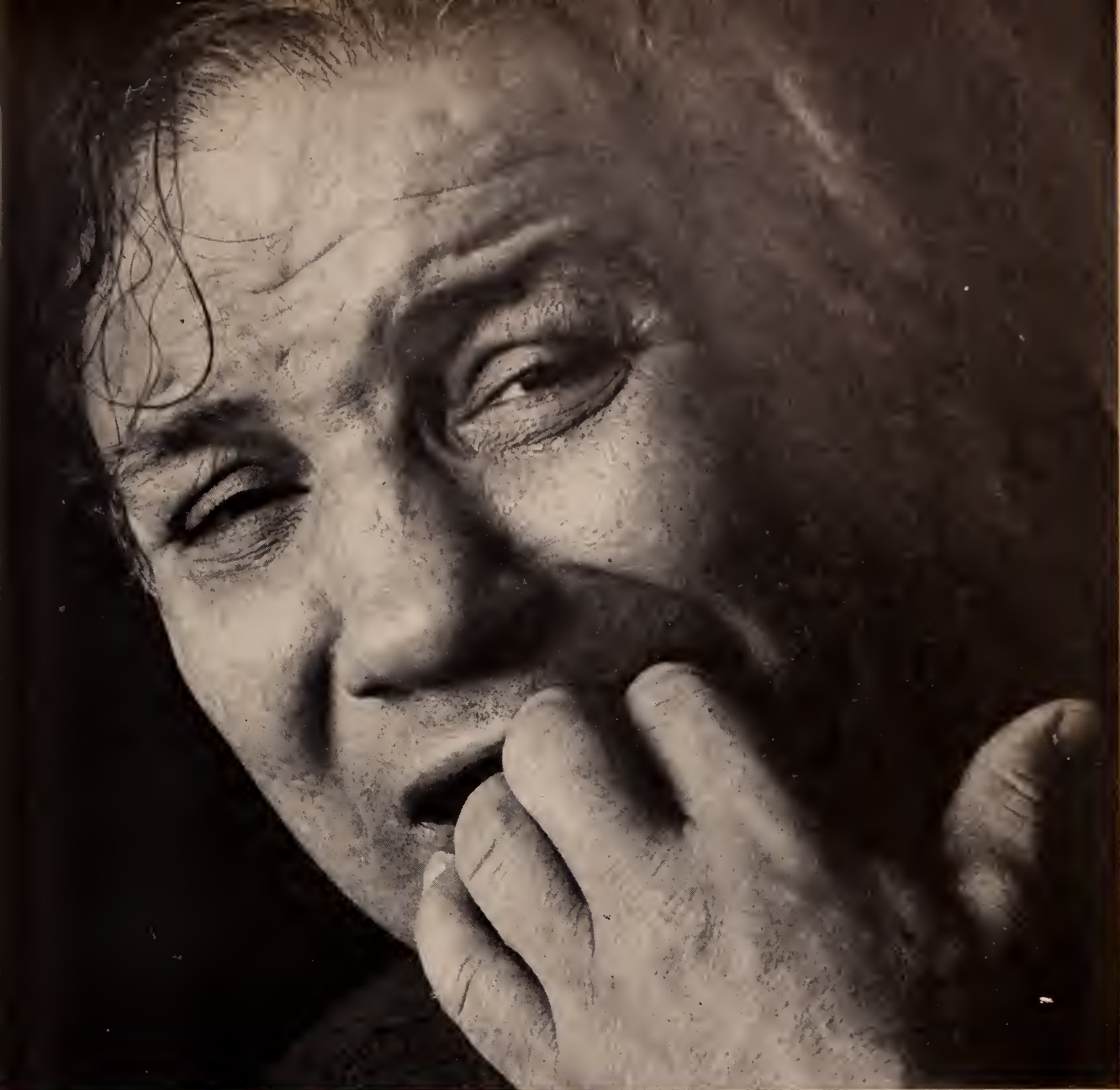
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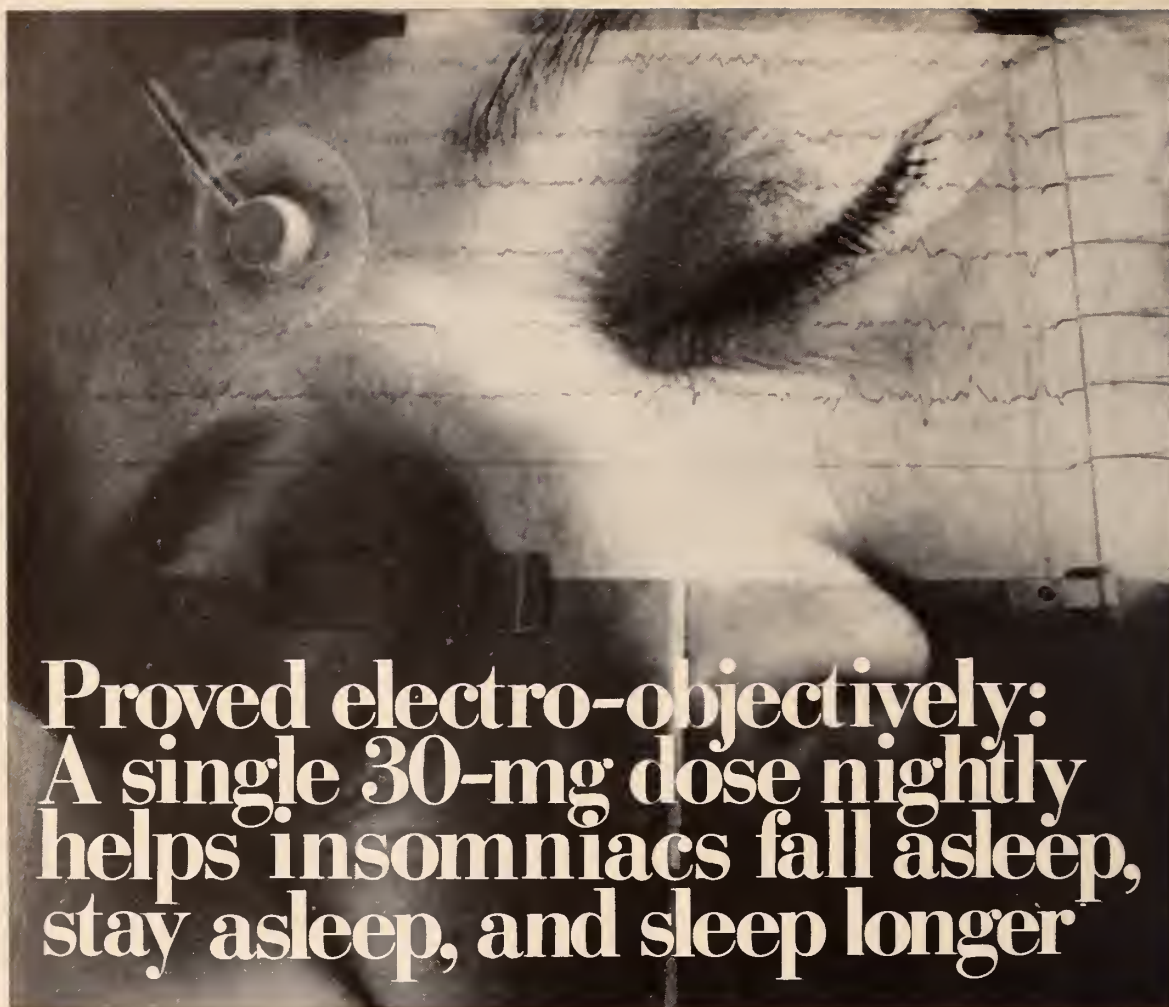
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Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,⁴ Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

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Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

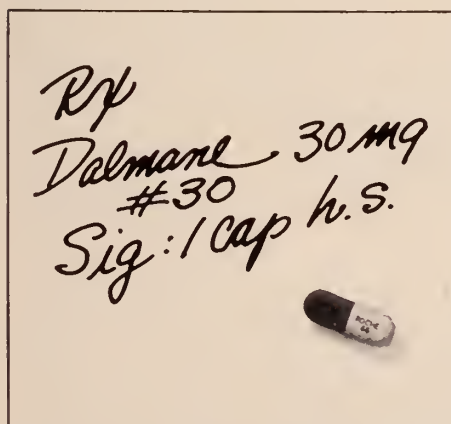
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.³ Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., *et al.*: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., *et al.*: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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EDITORIALS

But the M.D. Makes Decisions

They all want to get in on the act: assistants, aides, psychologists, sociologists, physical education instructors, health teachers, technologists, and on and on—not to mention computers and data processing equipment. They offer to help us make decisions. But when it comes to *making* the decision, overseeing its implementation, and taking responsibility for it, then the doctor of medicine has to take a firm stand.

Theoretically, the medical scientist coolly weighs the consequences of each decision, and selects the one answer that best fits the facts, the prognosis and the clinician's previous experience. In practice, there are other components which can't be calculated that simply. The decision as to whether a patient with acute pulmonary tuberculosis should or should not go to the sanatorium, for example, has to be made in the light of his living conditions at home. If the poor scrub woman has a backache, cold logic might lead to the one recommendation: take the winter off and loll on the sands in Florida. But here some other elements intrude and make that an unacceptable decision. This is what is often meant by the phrase "the art of medicine" as distinguished from the "science"—that is, selecting courses of action which fit the emotional, financial, and personal factors, as well as the intellectual and scientific ones. And this is why, at some points, practice seems to depend on a hunch or mystique—or to give it a more elegant phrase, on "clinical intuition."

Sometimes we have to build moral or legal factors into the decision-weighting, thinking machinery. For example, should we commit a patient to a mental hospital, report failing eyesight to the employer of the school bus driver, let the airline know that the pilot is

an alcoholic, or the school janitor a homosexual, recommend an abortion? These involve matters beyond the strictly scientific. Yet the doctor must make the decision. He can't pass the duty on to anyone else. As Harry Truman used to say: "The buck stops here."

Reporting the Epileptic

New Jersey laws had long required physicians to report cases of epilepsy to the local health department. Many physicians—perhaps most of us—never thought of epilepsy as a reportable disease. Sending these reports to local health departments often failed to achieve the purpose of restricting or limiting the driving license of epileptics. However, last September, the legislature enacted chapter 195 which made several welcome changes in the epilepsy reporting procedure. The obligation now applies only if the patient is over the age of 16, so the pediatrician is not harassed with the need to report every recurrent seizure in a child. Also, the requirement applies only when the condition "persists despite treatment," so that if your patient's seizures remain under control, his case is not reportable. The duty now is to report the facts to the Director of the Division of Motor Vehicles and not to the Health Department. The new statute provides that the existence of the disorder "shall be kept in the confidence of the Division of Motor Vehicles." It forbids the use (or even the revelation) of the fact except in connection with automobile privileges. Finally, the statute avows that one of its purposes is "to assure that no person is unwarrantedly denied the privilege of operating a motor vehicle" and requires a medical screening panel through the State Health Department. The Division (of Motor Vehicles) provides us with simple one-page reporting forms.

In our profession we are sometimes troubled by a conflict between the need for preserving confidentiality, and the need for serving the

broader interests of society. Canon 9 of the current AMA "Principles of Medical Ethics" provides for revelation of confidences if the doctor "is required to do so by law or if it is necessary to protect the welfare of the individual or of the community." There is thus a dispensation offered at the highest levels of organized medicine. Furthermore, we practice by virtue of a state-granted license, and cannot claim a right to do so in violation of a state law. The reportability of contagious diseases and gunshot wounds has never been questioned on moral or ethical grounds. An automobile in the hands of a driver undergoing a seizure is a dangerous weapon indeed. Finally, the physician who neglects to report an epileptic (or patient with unsuccessfully treated or untreated periods of petit mal, grand mal, or motor incoordination) opens himself to professional liability litigation, if such a patient injures or kills someone when he loses control of the car in a seizure.

Thus, ethics, morality, good citizenship, and common sense all combine to remind us to conform to chapter 195 of our state's laws of 1970.

Perils in Pursuing Perfection

Some physicians think that they are in the business of trying to make people normal, and to make organs function perfectly. We take it for granted that it is desirable to be free of symptoms, to achieve perfection in organic function, and to squeeze into the vague but desirable mould of "the normal."

There is no way of achieving the ideal. But we try. We aim at ideal weights, and ideal blood counts, and ideal x-ray findings. We assume it would be cause for congratulations if we could get the harassed, worried, hypertensive executive to take it easy. But we forget that if he succeeded in taking it easy, his business might collapse. It needs a compulsive, self-driving, potentially hypertensive boss to

keep it going in high gear. If the doctor succeeded in relaxing the executive to the point of hypotension, profits would fall, stockholders would swear, and laid-off employees would then develop high blood pressure.

Peptic ulcer is said to be related to repressed hostility acting on a hyperacid, hypermotile stomach. If we achieve perfect digestion, the victim will either exhibit his hostility (instead of repressing it), or give up the fight entirely and stop being hostile. If he does that, he may lose the passion which kept him going. If he exhibited the hostility instead of repressing it, he would exchange an unpleasant but benign ulcer for a dangerous, possibly fatal coronary.

Let's face it, neither the human body nor the human mind, nor — for that matter, the human soul — is perfectible. Crises keep us toned up. Without them, we would lose muscle tone and emotional drive. But with crises we have other problems. People are entitled to emotional storms — even to occasional "break-downs" of such severity as to require hospitalization. The neatly patterned carpet or blanket, has a chaotic pattern on the underside. It is possible to have a body with no tension and a mind with no worry — a dead body, of course. The most important tasks of our time cannot be performed by men who are free of anxiety. Anxiety is the motor that drives us. A machine can function free of anxiety — but not a human being. And you can't take pleasure in being human, if you have to brood about your score. If you can't enjoy your own abilities, because of a hopeless pursuit of perfection, you will lose on both scores. You won't make enjoyable use of your limited potential — and you won't achieve perfection either.

The human being has all kinds of foibles — physical, spiritual, and emotional. But since he is stuck with those limitations, he should learn to enjoy them. Perhaps this is our mission: to show how our patients can live with their modest human skills rather than to send them off on the wild goose chase after the mythical norm.



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A triumph over trichomoniasis

The male urogenital tract is by far the main source of reinfection in trichomonal vaginitis.

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Just as Flagyl is the best agent available for eradicating trichomonal infection from extravaginal sites in women, it is the only agent capable of eradicating demonstrated trichomonal infection in men.

Because of published reports of consistently high cure rates—often up to 100 percent—and a relatively low incidence of side effects, Flagyl has become the agent of choice for trichomonal vaginitis.

Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of

Monilia, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets 250 mg.
Vaginal inserts 500 mg.

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ORIGINAL ARTICLES

Limitations on the use of cyclandelate drugs in psychogeriatric cases are here spelled out.

Vasodilators in Geriatric Psychiatry

David P. Birkett, M.D./Paramus

The object of this study was to see what sort of elderly psychiatric patient is most likely to respond to a vasodilator. Earlier studies¹ have yielded conflicting results. In some, these drugs have not been effective. Other studies² have found a definite response. Perhaps this type of drug is more effective in arteriosclerotic psychosis than in senile dementia. However, clinical criteria for distinguishing between arteriosclerotic and senile psychoses are vague and not well defined.³

The patients' state at the beginning of this trial was evaluated by questionnaires covering the entire mental status and by a checklist of physical signs and symptoms related to arteriosclerosis, as well as by conventional case histories and examinations.

Vasodilators may be divided into those which act directly by relaxing smooth muscle (for example, papaverin and its derivatives) and those which act by being adrenergic and ganglionic blocking agents (for example, nicotinic acid and its derivatives). Several drugs of both classes have been shown experimentally to increase cerebral blood flow. Of course, such an increase in cerebral blood flow does not necessarily mean that a drug will produce clinical benefit in cerebral arteriosclerosis.

mandelate) is a generalized smooth muscle relaxant. Most of its pharmacologic properties are similar to those of papaverin and of many synthetic "antispasmodics" promoted primarily for effects on non-vascular smooth muscle. Cyclandelate* appears to produce little serious toxicity. However, doses high enough to augment blood flow appreciably are associated with a high incidence of unpleasant side effects⁵ including flushing, tingling, headache, dizziness, and sweating. The drug is in widespread clinical use, so that a study of the present type was not considered to raise any ethical problems. It is to be assumed that these patients would normally, in the customary and ethical treatment of their condition, have received a trial of this kind of medication anyway.

These were 24 ambulatory patients over the age of 65 in the Psycho-Geriatric Unit of Bergen Pines County Hospital. We excluded:

1. Patients with previous histories of hospitalization for schizophrenia.
2. Patients with previous histories of hospitalization for major affective disorders which had definitely responded to electric shock treatment or antidepressant drugs.
3. Patients with brain tumors, history of

Cyclandelate* (3-3-5 trimethyl cyclohexyl

*Cyclospasmol, Ives Laboratories Inc.

brain surgery, or neurosyphilis. Patients were selected at random from the remainder of the ambulatory population in the unit.

Patients over the age of 65 who are admitted to the County Hospital and are found to be ambulant but who have mental disturbances which make it impossible for them to be cared for at home are transferred to the Psycho-Geriatric Unit, after a brief investigatory stay in the Psychiatric Admission Unit or medical or surgical wards of the hospital.⁶ The unit is in a pleasant new building and the patients are more intensively treated than is usually possible for many patients of this type. Facilities in general and staffing ratios in particular are exceptionally favorable.⁷ (It has been noted that in studies of psychiatric drugs in general such favorable circumstances tend to be associated with less striking drug responses than are found among relatively neglected backward patients.)

Method

At the outset of the study, all patients were examined and an *Arteriosclerosis Questionnaire* was completed for each patient. The Mental Status Examination Record (MSER)⁸ was also developed for each patient. A conventional type psychiatric case history was also completed.

The *Arteriosclerosis Questionnaire* consisted of seventy-five items. These items were grouped into cardiovascular system and neurologic findings. Cardiovascular items included the presence or absence of thickened radial arteries; locomotor brachialis; kinked carotid arteries; temporal artery pulsation; peripheral pulses in the legs; retinal artery changes; hypertension; cardiac enlargement on chest x-ray; aortic changes on chest x-ray; and/or electrocardiographic abnormalities. Neurologic items included the presence or absence of a paralysis of sudden onset; history of epileptic fits or convulsions after the age of 50; signs of unilateral spasticity or weakness and positive Babinski responses; signs of bilateral spasticity and weakness with bilateral Babinski; (pseudobulbar palsy) or

any of the classical syndromes of individual artery obstruction (e.g. posterior inferior cerebellar artery syndrome).

The Mental Status Examination Record (MSER)⁸ was evolved by the Biometrics Department of the New York State Department of Mental Hygiene. It is a check list of emotional symptoms which covers the same ground as the conventional mental status. Many of the items are graded in five degrees ranging from 0 through slight, mild, and moderate to marked. It has been accepted for general use by the Mental Hygiene Departments of five states and the National Institute of Mental Health.

Fourteen of our patients were female and ten were male. Patients were randomly divided into two groups and the patients in one of these groups discontinued any phenothiazine drug they were on at the beginning of the project. The patients in the other group continued a phenothiazine drug if they were already on one. Thus, as regards phenothiazine drugs, there were three groups: (a) one group who had never received phenothiazine drugs; (b) one group who discontinued phenothiazine drugs for the duration of the project; and (c) one group who were already on phenothiazine drugs and continued them at the previous dosage level during the project.

There was no other discontinuance of drugs for the project.

Apart from phenothiazines and topical medications the following other drugs were prescribed during the course of the study: chloral hydrate at night if needed (10 cases); laxative of choice if needed (five cases); anti-parkinsonian drugs, antibiotics, antacids, (two cases each); insulin, digoxin, chlorothiazide and multivitamin capsules (one case each).

The Crichton Behavior Rating Scale⁹ and the Brief Psychiatric Rating Scale¹⁰ were administered at the beginning and at the end of the project. Also a global estimate was made

as to whether the patient had improved on cyclandelate.* The Side Effects Rating Scale consisted of 25 items such as nausea, dry mouth, loss of appetite, drowsiness, and skin rash. Each of these items was marked in three grades (mild, moderate, and severe). General inquiry was made of the patient and nursing staff concerning any other side effects.

Dosage and Duration of Study

Cyclandelate* was administered to all patients in doses of one capsule (200 milligrams four times a day for one week and then two capsules four times a day for three weeks. If the behavior of any patient became such as to require psychotropic medication, the cyclandelate* study was terminated and the patient given the medication required in the physician's judgment. Such a patient was considered a treatment failure for cyclandelate,* if this event occurred after the tenth day of cyclandelate* medication. If it occurred prior to that time, the patient was considered a dropout from the study and another patient brought into the study to make up the total of 24 patients. (By these criteria there were one treatment failure and two dropouts).

Division of Patients into "Improved" or "Worse"

This was done by combining the results of the Crichton Scale,⁹ the Brief Psychiatric Rating Scale,¹⁰ and the global estimate of change. Patients who showed an improvement of two degrees on any of the scores on either the Crichton Rating Scale or the BPRS were placed in the "improved" group provided that they were not rated as worse on any of the other scores or on the global estimate. Those who showed deterioration of two degrees or more on any of the scales on either the BPRS or the Crichton Rating Scale were rated as "worse" provided that they did not show improvement on any of the other scales or on the global estimate. (The treatment failure was included in the "worse" group.)

Patients who did not come into either of these categories were regarded as falling into the intermediate group and are not further

considered in the statistical results. (The two dropouts are also not considered in the statistical results.)

Results

Using the criteria indicated, eleven patients were judged as being "improved" and five patients were judged as being "worse." There were no significant differences between these two groups on the arteriosclerosis rating scale. There was a tendency for patients with absence of the posterior tibial pulses to fall into the "improved" group although this difference did not reach the accepted level of significance. None of the other signs or symptoms of vascular disease showed any trend. Discontinuance of phenothiazines did not affect the outcome.

We noted several significant differences between the two groups on the MSER, which was completed at the outset of the study. Generally there was a trend for patients with severe disorientation and confusion as recorded on the MSER to fall into the "worse" group. T-test on the mean scores of the two groups for orientation (time, place, person) and recent memory showed the "worse" group were more severely disoriented for time and person and had a more severe impairment of recent memory at the outset of the study than did the "improved" group.

The conventional case histories were divided into the "improved" and "worse" groups and these were presented to an independent physician who was unaware of the nature of the drug being used. His impression was that the "improved" group had shown less severe mental disturbance at the beginning of the study than had the "worse" group. He did not consider that either of the two groups showed any greater tendency than the other to have symptoms of cerebral arteriosclerosis.

Flushing was observed in two patients in the first week, but was not a continuing problem. There were no complaints of headache,

*Cyclospasmol, Ives Laboratories Inc.

tingling, or excessive sweating. Two patients complained of epigastric discomfort and a feeling of acid fluid coming up to the mouth. One patient was dropped from the study after three weeks because of increasing agitation. (However, this symptom persisted after discontinuance of cyclandelate*.)

Two patients complained of being cold. This occurred after they had been on the drug for three weeks and was not complained of after the drug was stopped. One of these two patients was found to have a low protein-bound iodine but otherwise no thyroid abnormality or other concurrent illness was found to account for this symptom.

Discussion

If it is assumed that cyclandelate* is effective in relieving psychiatric symptoms in psychogeriatric patients, then these results suggest that it is most effective in patients who do not have severe degrees of disorientation and memory loss. Signs or symptoms of arteriosclerosis or a clinical picture suggestive of cerebral arteriosclerosis (rather than senile dementia) did not prove to be a predictor of good response to cyclandelate*. Absence of the posterior tibial pulse in the group of good responders was not significant and was not accompanied by any trends to good response in patients with other signs or symptoms of peripheral vascular disease.

Several possible explanations of these results can be suggested. Perhaps improvement is more easily noticed in mildly ill cases. A slight degree of improvement in a completely confused mental patient might not produce any clinically observable effects. The same ratio of improvement in a patient who is not yet completely out of touch with the world may be more noticeable and more clinically useful.

It is also possible that physical side effects may be more disturbing to a patient who is so demented that he is not aware of what is

happening to him. His response to these side effects may be increasing agitation, which causes him to be regarded as clinically worse.

It is probable that, even if the evidence in their favor is only slight, most clinicians will continue to use vasodilators in the treatment of mental disorders in the elderly.

Good arguments may be offered using unnecessary medication in this age group. Apart from the possibility of unpleasant side effects there is considerable expenditure of nursing time in administering medication to demented and uncooperative patients. It is, therefore, suggested that vasodilator drugs should not be used in this group of severely ill and severely demented patients. It is also suggested that the history of stroke, or of signs or symptoms of arteriosclerosis, is not a useful criterion for predicting response to vasodilator drugs.

Our purpose was not to decide whether cyclandelate* is an effective drug but to decide which patients it is most suitable for psychiatrically. The results of this study do not justify any conclusions on the effectiveness of cyclandelate.*

Summary

A single blind non-crossover study of the use of a vasodilator drug, cyclandelate,* in 24 psychogeriatric patients is described. Response to the drug was evaluated by means of the BPRS, Crichton Rating Scale, and a global physician's estimate. The patients' condition at the beginning of the trial was estimated by conventional case histories, the MSER, and on Arteriosclerosis Rating Scale.

Patients were divided into good responders and bad responders. Good responders proved to have had less impairment of orientation and recent memory on the MSER at the outset of the study. Clinical evidence of arteriosclerosis was not a useful predictive factor. None of the items on the Arteriosclerosis Rating Scale had any predictive value.

The use of vasodilator drugs in psychogeriatric

*Cyclospasmol, Ives Laboratories Inc.

ric patients is discussed and it is suggested that they should be reserved for patients not showing the most severe degrees of disorientation and confusion and that clinical evidence of arteriosclerosis should not be a factor in determining their use.

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Bergen Pines Hospital

Home-Poisoned Children

There's no place like home for accidental poisonings. What your patient can do to prevent accidental poisonings is discussed in *Protecting Your Family From Accidental Poisoning*, by Arthur S. Freese. This new Public Affairs Pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York 10016.

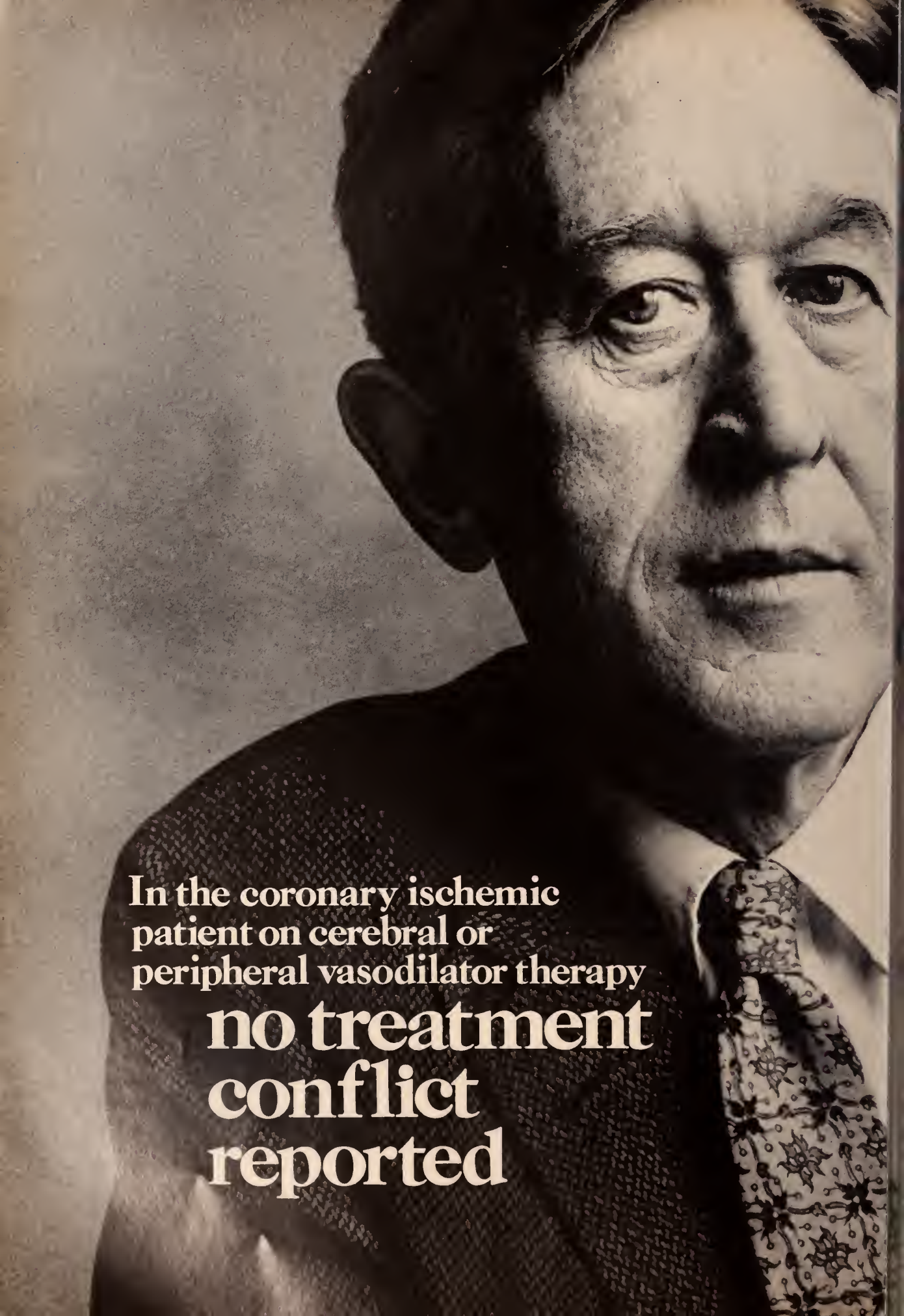
Mr. Freese pays special attention to the protection of children, since, as he points out, "toddlers and preschoolers are the victims in about 90 per cent of all accidental poisonings." His advice is concise, practical, and effective. If, despite all precautions something poisonous is swallowed, hold on to the remains of what's been taken—and call for help immediately. Try the doctor first, then the local Poison Control Center or the community hospital or the police. Lifesaving home emergency measures are also reviewed in the pamphlet and summarized in a handy chart. Freese also covers several different kinds of food poisoning which can occur at home and in public eating places.

The final section of the pamphlet is concerned with lead poisoning and with mercury pollution—two problems that call for more than simple precautionary home measures.

Childhood lead poisoning, Freese writes, "is especially prevalent in neighborhoods of deteriorating housing. And this poisoning can be eliminated when society is ready to commit the money for correcting the conditions that cause it. . . . Most serious of the effects of lead poisoning is damage to the central nervous system. Parents in old housing must make every effort to keep their children from contact with old paint flakes. But obviously what is urgently needed—along with more regular programs of detection and diagnosis—are preventive programs to cover up old lead paint and plaster."

Mercury pollution, much in the news recently, is another problem that requires community action, for it is "an intolerable threat to . . . health and safety . . ."

Freese alerts the reader to other dangerous metals, and warns that containers made with zinc, antimony, cadmium, or lead should be avoided. Unglazed pottery used for cooking or serving has also been considered a source of lead poisoning. And because lead has been used to coat plastic beads and other jewelry to simulate pearls, Freese urges that you not let "children put these into their mouths, and avoid doing so yourself."

A black and white portrait of a middle-aged man with dark hair, wearing a dark suit jacket, a light-colored shirt, and a patterned tie. He is looking slightly to the right of the camera with a serious expression. The background is a textured, mottled grey.

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- complications in the treatment of diabetes, hypertension, peptic ulcer, glaucoma or liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators¹⁻⁴ have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement^{2,3} and observation of clinical improvement.^{1,3}

Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODILAN tablets, isoxsuprine HCl 10 mg. and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories. References: (1) Clarkson, I. S., and LePere, D. M.: *Angiology* 11:190-192 (June) 1960. (2) Horton, G. E., and Johnson, P. C., Jr.: *Angiology* 15:70-74 (Feb.) 1964. (3) Dhrymiotis, A. D., and Whittier, J. R.: *Curr. Ther. Res.* 4:124-128 (April) 1962. (4) Whittier, J. R.: *Angiology* 15:82-87 (Feb.) 1964.

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and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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New electronic methods have made possible better understanding of pressure, flow, and volume relationships of the chest/lungs system. Dr. Cohen here describes these technics in office and outpatient evaluation.

Diagnostic Procedures in Pulmonary Disease*

Burton M. Cohen, M.D./Elizabeth

Although only lately has clinical lung physiology joined what Himsworth¹ calls "development toward certainty and precision," the central role of respiration has been recognized since Hippocrates.² Newer diagnostic airways technics, fully applicable to the office practice of internal medicine,³ have also made clinical research for ambulatory patient care a reality.

The artificial gymnastics of conventional spirometric testing do not yield the most sensitive, precise, or complete definition of the

forces needed to overcome the resistance to movement of the lungs and thorax.⁴⁻¹⁰ As the newer methods have disclosed the contributions of lung tissues, chest wall, and upper and lower airways to total breathing resistance, a contemporary pulmonary terminology has evolved (Table I). "Resistance" is the term properly used to speak of the important pressure, volume, and flow interrelationships calculated during respiratory motion,¹¹ although its reciprocal "conductance" is becoming as popular. When both these measurements are correlated with the specific volume of thoracic gas at which they were recorded, the terms "Specific Airway Resistance" and "Specific Conductance," are used.

TABLE I
Glossary

C compliance (given in cc/cm H ₂ O)	
C _l	Compliance of lung (pulmonary)
C _{ew} (or C _w)	Compliance of thorax
R resistance (given in cm H ₂ O/l/sec)	
R _{uaw}	Resistance of upper airway
R _{law}	Resistance of lower airway
R _{aw} (R _a)	Total airway resistance
R _{lt} (R _{tl})	Resistance of lung tissue
R _{ew} (R _c)	Resistance of the chest wall
R _l	Total Pulmonary Resistance
R	Total Respiratory Resistance
G (G _{aw}) conductance (given in l/sec/cm H ₂ O)	
sR _{aw} (sR _a)	= Specific Airway Resistance
sG _{aw} (sG _a)	= Specific Conductance
EPP Equal pressure points: where pressure within the airway is equal to pleural pressure	
R _{us}	Upstream Segment (Peripheral): resistance of those airways running from the alveolus to the EPP with static recoil pressure as the driving force
R _{ds}	Downstream Segment (Central): resistance of those airways running from the EPP to the mouth, with the difference between the alveolar pressure and the static recoil pressure as the driving force.

Two physiologic segments of airway resistance derive from the concept of "Equal Pressure Points" (EPP), the sites where the pressure within the airway equals the pleural pressure. At the end of forced expiration, despite very high pressures developed at the pleural lung surface, the lungs still contain large amounts of air, something explicable by air trapping due to complete closure of part of the tracheobronchial tree. This air which remains (even if one cannulates a bronchus) is presumably sequestered by closure of the small airways, probably at the level of the respiratory bronchioles. During forced exhalation lung volume decreases, the traction exerted by elastic and collagenous fibers on the small airways

* Presented at the New Jersey Chapter, American College of Physicians, Trenton, November 11, 1970. Dr. Cohen is Associate Professor of Clinical Medicine, College of Medicine and Dentistry of New Jersey at Newark.

diminishes, and airway diameter is reduced. The decrease in airway caliber causes a rise in resistance offered by the airways to the flow of gas from the alveoli, resulting in a progressive drop in intraluminal pressure relative to alveolar pressure. The airways collapse when the joint attempt of intraluminal pressure and

the traction exerted on the airways walls is insufficient to keep them open. "Residual Volume" is now considered as the amount of air left in the chest at the end of forced expiration when airways closure prevents further exhalation. Residual Volume falls when fibrous traction on the airways walls is in-

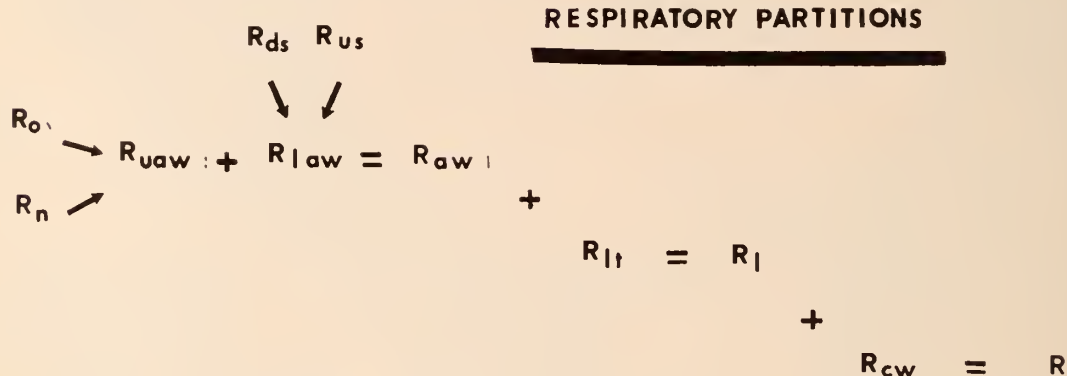


Figure 1—Schema of resistance measurements in respiratory physiology. R_o represents resistance measured during oral breathing, and R_n represents resistance measured during nasal breathing. R_{uaw} and R_{law} represent resistances of the upper and lower airways, respectively; these total R_{aw} , R_{ds} , and R_{us} represent the downstream and upstream resistances, respectively. R_{lt} represents resistance of the lung tissues, R_l represents total pulmonary resistance, R_{cw} stands for chest wall resistance and R for total respiratory resistance.

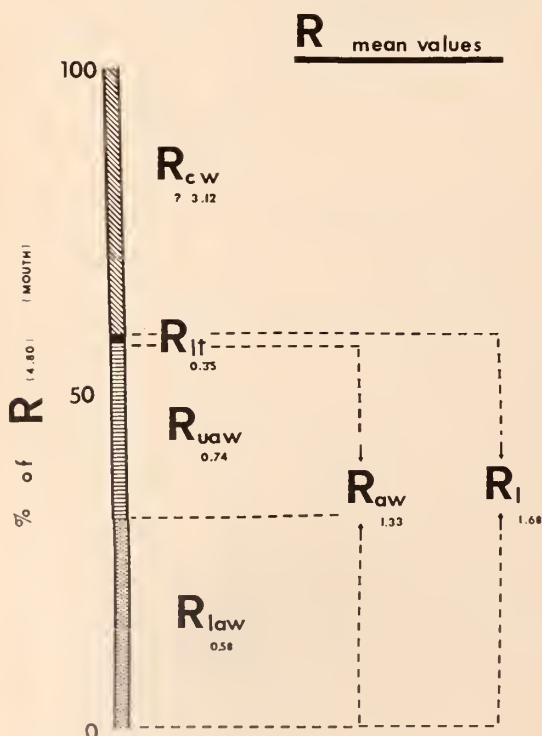


Figure 2—Mean numerical values in cm H₂O/l/sec. for representative respiratory resistances tabulated from the literature. Symbol designations are those explained in the caption of Figure 1.

creased, as in lung fibrosis, and rises when the tension on the walls is diminished, as in the senile and obstructive emphysemas. Resistance is classified as that in the "upstream segment"—those airways running from the alveolus to the EPP, where static recoil pressure is the driving force, and as that in the "downstream segment"—comprising the airways running from the EPP to the mouth, where the difference between alveolar and static recoil pressures is the driving force. These have been called "peripheral" and "central" resistances, and conditions affecting them separately categorized as "small" and "large" airways diseases.

A schema has been developed incorporating these major resistance compartments, or "partitions," and includes designations as to whether these were calculated during oral (R_o) or nasal (R_n) breathing (Figure 1). All mean resistance values, and their relative contribution to total pulmonary and respiratory resistances, are only tentative (Figure 2) because few investigators have done simul-

taneous or sequential determinations of all indices in the same patients, or in more than a handful of patients, and some of the pertinent literature is unclear as to the particular component or combination of resistances actually calculated.¹³ Although direct values for measurement of lung tissue and chest wall resistance, as for compliance, require pleural or tracheal punctures or esophageal intubation and are clearly unsuitable for evaluation of office patients, the major part of respiratory resistance can be determined without such "invasive" technics.

The most familiar approach measures airway resistance with either a volume or pressure body plethysmograph. When a subject sits within the air-tight "body box," changes in his intra-alveolar pressure during breathing cause proportional volume and pressure changes within the chamber. These alterations, and those of his mouth pressure and flow sensed by instruments mounted at the breathing mask, are inscribed as flow-volume and pressure-volume loops on the face of an oscilloscope connected through electronic amplification. Resistance calculations are made during shallow panting; during one such maneuver, a shutter valve occludes the mouthpiece for a few seconds, and, as the subject continues panting, mouth and alveolar pressure become virtually identical. The relationship between mouth and plethysmograph pressures is shown as a sloped line on the oscilloscope screen. Resistance is calculated from these traces according to formulae,¹⁷ or can be conveniently read directly with a calibrated disc attachment for the tube face.[†] The curves are photographed for retention and review. Our five-year experience with the plethysmograph confirms the ease with which even wheezing, breathless, severely handicapped patients are able to cooperate and coordinate with the technics. Claustrophobia has been an infrequent contraindication.

Practically, airway resistance measurements differentiate between the responses of populations and individuals to a variety of both bronchoconstrictor and bronchodilator

stimuli with great sensitivity¹⁸⁻²⁵ and reveal breathing abnormalities when standard forced vital capacity tests are not helpful. In one United Kingdom experience,²⁹ these were the only measurements from a comprehensive screening battery that could distinguish the effects of varying levels of air pollution on the breathing of the inhabitants of two towns.

Resistance changes are more likely to parallel the clinical condition of the patient than are the derivatives of spirometry, finally resolving the paradox of symptomatic betterment of individuals whose vital capacity determinants were "fixed," something attributed formerly to psychosomatic, rather than real changes. While some think that spirographic indices are in good general agreement with airways resistance figures³⁰, most workers hold that this relationship is not valid, and that it may be inappropriate, on both statistical and physiologic grounds, to attempt a correlation.³¹ Plethysmograph testing does not alter or distort the very factors being measured, a definite handicap of forced expiratory measurements.³²⁻³⁴ In addition to airway resistance and conductance sensitivity to functional and clinical status changes, alterations in their values may anticipate and precede major deterioration in patient well-being.³⁵

The plethysmograph also measures the functional residual capacity of the lungs with great accuracy³⁶. The "volume of thoracic gas" so recorded is greater than that calculated from gas dilution methods for those with obstructive airways diseases, and is closest to x-ray estimates of lung capacity made in the same patients. The numerical difference between "body box" and dilution estimates is often cited as another index of "air trapping"³⁷⁻⁴¹; after therapy, the values obtained by the three methods begin to approach one another.

Airway resistance figures are more valuable if they are related to the volume of thoracic gas.⁴²⁻⁴⁵ While airway resistance falls as lung

[†]Generously made available to us by Dr. Domingo Aviado, School of Medicine, University of Pennsylvania.

volume increases in normal individuals, in patients with chronic obstructive lung disease resistance rises rapidly as the lung becomes progressively hyperinflated.⁴⁶⁻⁴⁹ The use of Specific Airway Resistance and Specific Conductance data, taking account of the volume and resistance changes, smooths out the variability of lung test figures which are so common, and allows consistently accurate estimates of airways changes, while standard spirometric determinants are influenced in only 65 to 70 per cent of such instances,⁵⁰⁻⁵² with a lone dissent.⁵³

The dichotomy between the responses of the plethysmograph and the spirometer may, in part, be a matter of inherent sensitivity differences in the apparatus. These two methods are probably recording events in two different parts of the bronchial tree, the upstream and downstream segments, rather than in the same site. If one gives isoproterenol to normal subjects, their airway resistance falls, while forced expiratory volume and expiratory flow rate tests are unchanged.⁵⁴ Normal airway resistance and decreased maximum expiratory flow rates have been reported in chronic obstructive lung disease ("emphysema with little airways obstruction"),^{55,56} in alpha-1-antitrypsin deficiency,⁵⁷ and in the asymptomatic phase of asthma,⁵⁸ as well as in papain-induced emphysema in the hamster.⁵⁹ Conversely airway resistance can be elevated in the presence of obstructing lesions of the larynx and trachea, although forced vital capacity tests remain normal.⁶⁰ Resistance figures probably reflect the behavior of the large intra- and extra-thoracic airways ("central" or "downstream"), while forced expiratory tests "clearly reflect a complex interplay among airway geometry, airway compliance or compressibility, and lung elastic recoil"⁶¹ ("peripheral" or "downstream").⁶²⁻⁶⁷ The most comprehensive approach would include forced vital capacity and plethysmographic estimates made in concert in the same patient. From an epidemiologic and preventive medical standpoint, the optimal stage to begin the treatment of obstructive lung disease is the point at which airway resistance is elevated, but the

spirogram is still normal.

The oscilloscope photographs are informative. The normal flow-volume curve is a narrow, elongated loop or S-curve. The trace in restrictive disease is normal in contour, but much shorter in length. Bizarre traces are inscribed in the obstructive airways diseases and show (1) rotation of the loop clockwise, (2) widening along the volume axis, (3) "figure-of-eight" contours, (4) exaggeration of the normal sigmoid curve, and (5) a terminal, end-inspiratory projection, in various combinations.⁶⁶⁻⁷¹ These abnormalities are reversed, or become less pronounced, with effective treatment.

Determination of nasal airways resistance has been made possible by the availability of complex, sensitive electronic apparatus during the past decade.^{72,73} The "anterior rhinometric" approaches are not widely used, because of technical factors, although Stoksted and his group have applied this method extensively.⁷⁴⁻⁷⁷ Modifications of the older, "posterior rhinometric," techniques of Spiess⁷⁸ are more convenient. One method derives nasal flow resistance values from the differences between the values recorded during nasal and oral breathing of subjects in the plethysmograph.⁷⁹⁻⁸¹ Another employs oral or oro-nasal masks and small-caliber tubes passed between the closed lips over the tongue to sense changes in the oral pharynx.⁸²⁻⁸⁴ Nasal resistance data from these two methods are in good general agreement in the same population and from laboratory to laboratory. These determinations should be recorded at a specified, uniform flow rate, although critical data can be obtained by estimates of nasal patency depending only upon pressure changes.^{85,86} One can determine the contribution of each nasal passage to total nasal resistance as well as the contribution of nasal resistance to airways, total pulmonary and total respiratory resistances. The nasal resistance generally is responsible for 47 to 62 per cent of total airways resistance during nose breathing, and while normal subjects can generally compensate for nasal obstruction by a powerful pul-

monary action, mouth breathing may occur, even if the nasal passages are normal, if lung function is reduced by heart or pulmonary disease.^{91,92} Observations documenting the profound repercussion upon lung function and the work of breathing from abnormalities in the nose or nasal inhalation of irritants has suggested the existence of a nasal-pulmonary reflex arc.⁹³⁻⁹⁵ This neural reflex hypothesis is supported by evidences of rises in lower airways resistance after the stimulation of receptor sites in the nose and nasopharynx,⁹⁶ by changes in nasal patency after exercise, with⁹⁷ or without autonomic stimulation and blockade,⁹⁸ and from nasal blood vessel responsiveness to drugs and interruption of the cervical sympathetic nerve supply.⁹⁹ Nolte and Ulmer¹⁰⁰ and the author^{101,102} have demonstrated that resistance to nasal airflow is commonly high in patients with emphysema and bronchitis, adding a further burden to the breathing restrictions from the pulmonary ailment. If these patients are treated with phenylephrine, either as nose drops or spray, or combined with isoproterenol for mouth inhalation, one observes a greater improvement in nasal, lower airways and total resistances, than if isoproterenol alone was inhaled. Patients with obstructive airways diseases, like the astronauts, will probably breathe more easily if their nasal passages, as well as their lower airways, receive active therapy.

Nasal flow technics are more accurate in clinical drug trials which have usually relied largely on patient estimates of their own discomfort and relief of symptoms, or upon the attempts of highly trained observers to "score" the state of the nasal passages and their secretions.^{103,104} Nasal resistance measurements can distinguish the relative potency of drugs with an accuracy far superior to these traditional clinical notations,⁷³ and have yet to demonstrate adverse "rebound" effects following nasal decongestant drugs.

Total respiratory resistance, of which the lower and nasal airways segments form the

greater portion, and the lung tissue and chest wall elements the remainder, is useful for the evaluation of acutely ill, bedbound, anesthetized subjects in hospital and for uncooperative or claustrophobic patients or small children, situations in which the physical attributes of the body chamber prevent its use. The most convenient method, the oscillation technic of DuBois,¹⁰⁵ has received both laboratory animal¹⁰⁶⁻¹¹¹ and human¹¹²⁻¹¹⁴ trial.

Measurements are made by applying pressure oscillations at the mouth of the subject at the approximate resonant frequency of the respiratory system (usually 5-6 cps); at resonance the pressure needed to overcome inertia, and that needed to overcome elastic recoil, are of equal magnitude, but opposite sign, so that mechanical impedance becomes purely flow-resistive.¹¹⁵⁻¹¹⁷ The rapid pressure waves are produced by a woofer-speaker driven by a low frequency power amplifier; the flow and pressure signals generated at the mouth are amplified, displayed on the pre-calibrated axes of the oscilloscope, and photographed. The angles of the oscillation waves are measured from the photographs at the points where inspiratory and expiratory flow rates of 0.51 per second are attained, and the readings translated into resistance figures with a calibration graph.¹¹⁴ This method may discriminate best between normal subjects and those with pulmonary problems when the resistances are calculated during inspiration, at frequencies less than 5 cps and with meticulous attention to methodology.^{107,108,115} Like airway resistance, total respiratory resistance is a more meaningful estimate when it is corrected for the volume of thoracic gas of the subject,^{116,117} a correction that also enhances the precision of trials of bronchodilator drugs.¹¹⁸ Although the author uses plethysmographic data to derive thoracic gas volumes, the same type of information can be derived from measurements of chest X-rays taken at maximum inspiration.¹¹⁹⁻¹²¹ Volume correction by one or the other method is mandatory, if the current apparatus being marketed to record total respiratory resistance in epidemiologic studies, office diagnosis and

clinical drug studies is to have real value.

Lower airways, nasal flow and total respiratory resistance measurements can be obtained, with duplicate check determinations, in 20 to 30 minutes in untrained subjects. Esophageal, nasal and pharyngeal intubation, or tracheal and pleural punctures, are not needed. Once the apparatus is acquired, maintenance costs are minimal. The entire "resistance laboratory" fits comfortably into a room of 6 by 9 foot dimensions. Once inaugurated, these procedures yield practical information for estimates of disability and impairment and the impact of treatment in modifying the natural history of chronic obstructive lung disorders.

Summary

Although conventional spirometry is useful and informative, newer sensitive electronic methods have made possible better understanding of pressure, flow and volume relationships of the chest/lungs system. While certain segments of the resistance diagram

require airway or esophageal intubation or tracheal or pleural puncture, investigation of total respiratory resistance and the nasal and lower airways segments utilizes "non-invasive" technics suitable for office and out-clinic evaluation. Appreciation of altered nasal physiology, particularly in obstructive respiratory disorders, suggests important additional approaches to the treatment of patients with these breathing handicaps. Utilization of resistance figures is the most satisfactory way to differentiate between normal individuals and those with pulmonary problems, and to judge responses to a wide variety of airway-active stimuli, medical and surgical therapies. Considerations of space, economics and the value of the data derived support the practicability of these procedures for routine clinical use by the internist, pediatrician, allergist, anesthesiologist and thoracic surgeon.

The author will be glad to supply the bibliography upon request of any interested reader. Please address him at 230 West Jersey Street, Elizabeth, New Jersey 07202.

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New Hepatitis Suspect Registry

The American National Red Cross Blood Program has developed a hepatitis suspect registry using automatic data processing methods to identify suspected carriers of hepatitis. Dr. T. J. Greenwalt, national medical director of the Red Cross Blood Program, has explained that the registry will ultimately contain identities of blood donors known to the Red Cross suspected of being carriers of hepatitis. This list will be made available to other blood collection facilities on request. Even though the Red Cross accepts only voluntary donations, some individuals may be unaware that their blood could transmit hepatitis. Purpose of the registry is to provide additional means for determining whether certain blood donors should not be accepted because of the risk of transmitting hepatitis.

A master file at the Red Cross data processing center contains coded identification of all Detroit area blood donors suspected of being

carriers of hepatitis, a type of liver disease. This confidential list was compiled through names submitted to the Detroit Red Cross medical director by hospitals and through names of suspected hepatitis donors known to the Red Cross. Such donors on this list have already been notified. The Michigan Chapter transmits coded data on all Red Cross Blood donors in the region to the Virginia computer center which electronically checks each against the hepatitis registry. When a match is made the computer indicates that the blood should not be used. This information is relayed and the donor is advised.

The registry soon will be expanded to include the identity of hepatitis suspects voluntarily submitted by community blood banks and hospitals. Any non-Red Cross blood collection facility may use the registry now being developed by the Red Cross for the inclusion of the identities of hepatitis suspects.

This up-to-date monograph answers many of the questions about contraceptives.

The Present Status of Contraception*

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Contraceptive methods currently available, presently prescribed, and frequently used include the following: coitus interruptus, post-coital douche, spermicides, condom, diaphragm, rhythm, oral contraceptives, intra-uterine devices, and surgical sterilization. The advantages, disadvantages, indications, contraindications, and effectiveness are here reviewed for each method. Regardless of the statistical effectiveness of any method, one cardinal principle of choice must always be the esthetic acceptability to the individuals who will use it.

Coitus Interruptus

The withdrawal of the penis before ejaculation (coitus interruptus) is an old method still being used in some places. In a 1955 study,¹ it appeared that 15 per cent of the couples had used it at some time and 7 per cent were using withdrawal most recently. In England, it was found¹ that 20 per cent had never used anything else and 19 per cent had reverted to it after trying other methods.¹ The method is not popular in the United States now but is still used considerably in Europe and the Near East.² Its effectiveness (referring to pregnancy rate) is less than when mechanical and spermicidal contraceptives are used.² Failures are related to the escape of sperm from the penis before ejaculation. The over-all failure rate³ is 12-38 per cent. Coitus interruptus has distinct disadvantages. One is that it interferes with sexual relations, demanding self-control on the part of the male and is unfavorable for female orgasm. Also it requires physiological

and emotional discipline, and, in a sense, it is "messy."⁴

Post-Coital Douche

The post-coital douche attempts to remove the semen from the vagina mechanically. The addition of vinegar or one of the commercial douche mixtures to the water hopefully improves the effectiveness of the douche.² In the United States this method is used only among the poor and uneducated.² Deaths have been reported from the use of carbonated beverages as post-coital douches. The only reasonable use of the post-coital douche is as an emergency measure if a condom breaks. As a method it is inconvenient and ineffective; it is the least effective of all methods.² Sperm are found in the cervical mucus within 90 seconds after ejaculation. This hardly allows time for prevention of pregnancy by post-coital douching. Moreover, the antiseptics added to the douche often burn the vaginal mucosa and damage the vaginal flora.

Spermicides

Spermicides include the jellies, creams, foams, and suppositories *used alone* to immobilize the sperm on contact. These are simple to use, require no medical examination, and are relatively inexpensive. However, only the foams are used to any significant degree in the United States.² The vaginal leakage and excess lubrication, which prompts the frequent referral to these methods as "greasy kid stuff," are significant deterrents to

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its use. Foams, however, are the most effective form of spermicide, but all are considerably less effective than when combined with a diaphragm.² The vaginal foam yields 29 pregnancies per 100 women years.¹ The creams and jellies result in 37 pregnancies per 100 women years.¹

In 1965, 2 per cent of the patients surveyed were using a spermicide alone.⁴ Deterrents to its use were its messiness, the incidence of vaginal irritation or inflammation, and the clock watching that was necessary to fall within the limited time of effectiveness.

Condom

The condom is effective though it fails when it tears or slips off during intercourse. Couples who use the condom have a failure rate of 6 to 20 per cent.³ Additionally, and of importance, is the fact that the condom prevents the transmission of venereal disease.² Forty-three per cent of a group surveyed in 1955 had used the condom at some time during their marriage; in 1965 a similar query revealed a 42 per cent utilization at some time.^{1, 5} In 1955, 25 per cent of the patients reported the condom as the most recent method used; in 1965, the figure was 18 per cent.^{1, 2} Definite disadvantages to the use of this method are the interruption of the sexual act to put on the condom, the sensation of the sheath felt during coitus, and the irritation from the material of the condom or from the powder on it.⁴

Diaphragm

The mechanical barrier of the vaginal diaphragm alone is really not an effective contraceptive. The addition of a spermicidal cream or jelly to the diaphragm, serving as a lubricant as well as a spermicide, makes the combination effective. Ideally, a properly fitted diaphragm with a cream or jelly should result in only 2 to 3 pregnancies per 100 women years. In fact, the method has about 10 pregnancies per 100.^{2, 3} Failures are generally related to incorrect sizing or insertion, displacement during coitus or removal before the spermicidal effect of the cream or jelly is completed (about 6 hours post-coital).

The diaphragm must be properly fitted and therefore requires a pelvic examination. It requires motivation and purposeful behavior to be maximally effective and privacy for insertion. The genital manipulation is often distasteful. Vaginal irritation may occur from the rubber, the cream or jelly, or from inept, unhygienic manipulation during insertion.^{2, 4}

Before the advent of oral contraceptives, 25 per cent of couples in the United States used the diaphragm.² In 1965, 10% of couples used the diaphragm and 25 per cent had used it at some time in their marriage.^{1, 2}

The cervical cap is not used much in the United States, but is still used in Great Britain and Central Europe. It is somewhat less effective than the diaphragm and its failures are generally the result of inadvertent displacement.

Rhythm

The rhythm method is the only contraceptive modality currently sanctioned by the Roman Catholic Church. Its effectiveness depends on avoiding coitus on the days in which motile sperm and a fertilizable ovum could come together. Calendar rhythm involves tabulating 12 successive menstrual intervals and estimating the probable time of ovulation. Coitus is then allowed pre and postovulatory. Basal temperature rhythm requires taking basal temperatures daily and when the ovulatory rise has occurred, coitus is permitted 3 days later and to the next menstrual episode. Thus, only postovulatory intercourse is permitted.¹ In an anovulatory cycle, with no rise in basal temperature, the woman might run into the next period without the 3 day temperature rise following which coitus is permitted. In this method the days of coitus are reduced, particularly in basal temperature rhythm. This requires maximal physiological and emotional discipline and interferes with sexual relations.⁴ In 1965, some 30 per cent of Catholics in the United States used rhythm. Among Catholics, the use is directly proportional to the social and economic status.²

In a study of 409 women for 7,267 months on

calendar rhythm, there were 14 pregnancies per 100 women years.¹ In a similar study on basal temperature rhythm, with only post-ovulatory coitus, couples had 6.6 pregnancies per 100.^{1, 5} Failures may be associated with aberrant ovulation, even during a menstrual episode or the abnormal survival of sperm in the genital tract with resultant fertilization.

Oral Contraceptives

The oral contraceptives, now in general use, fall into two regimens of prescription, the combined and the sequential. The combination pattern consists of 20 or 21 identical pills containing estrogen and a progestational agent. These are taken either from the fifth to the twenty-fifth day of each cycle or more commonly, now, for 21 days and withheld for 7 days followed by resumption for 21 days, regardless of bleeding. Under the sequential regimen, 15 or 16 pills of estrogen alone are followed by 5 pills of estrogen with a progestational agent. Under both regimens the cessation results in withdrawal bleeding within a few days.

In 1968, 17 or 18 million women in the world were using oral contraceptives and an estimated 7 to 8 million in the United States.⁶ It was found² that 73 per cent were continuing after 12 months and 62 per cent after 24 months.

Oral contraceptives are the most effective non-surgical contraceptive method available. The combination pills have a pregnancy rate of 0.7 per 100 women years;² the sequentials 1.4 per 100 women years.⁷ Ideal statistics of 0.1 with combination pills and 0.5 with sequentials are often quoted, but these are not realistic figures. Failures are most often related to omission of pills.²

In addition to the high degree of protection, oral contraceptives have the advantage of freedom from genital manipulation and of being unrelated to sexual activity.² However, maximal attention and care to maintain regular administration is urgent and a high element of motivation is required.⁴

Rule of thumb contraindications to oral contraceptives include: liver diseases, history of thrombophlebitis, asthma, and migrainal headaches. Specifically, the United States Food and Drug Administration⁸ lists five contraindications:

1. Blood clotting disease, i.e., a history of/or current embolus, thrombophlebitis, and the like
2. Liver disease
3. Breast or genital carcinoma
4. Pregnancy
5. As non-valid indications—premenstrual tension or dysmenorrhea

The effectiveness of oral contraceptives is believed to be by way of anovulation. However, it has become apparent that while anovulation may occur it is not universally certain. Additional deterrents to pregnancy, with the oral contraceptives, include the creation of endocervical mucus inimical to sperm and the inadequately developed endometrium which exists.⁸

On the combination pills, the endometrium is a scant proliferative with an edematous stroma. On the sequential pills, the endometrium may develop into the secretory phase but usually not beyond the stage normally associated with the twentieth to the twenty-second day of the cycle. If ovulation and fertilization do happen to occur, implantation is virtually impossible on the endometrium of the stage encountered. Additionally, the menstrual flow is generally lighter because of the arrested endometrial development, lightest on the combination pills.

Disadvantages of the "pills" are the possible side effects. Ordinarily, the common side effects disappear in the first few cycles of administration⁸ (i.e., nausea, vomiting, breakthrough bleeding, breast engorgement, fluid retention and weight gain). These minor effects persist⁸ after 6 months in only 1 to 2 per cent of women.⁸ Silent menses, missed period, occurs in 5 to 7 per cent at least once in the first 24 months.⁸ Chloasmic skin discoloration or overactivity of the sebaceous elements may be a troublesome problem and may require withdrawal of the pills.^{2, 8} Nevertheless, as in pregnancy, many women find

that their acneiform skin problems are ameliorated.

Goldzieher⁹ reported that most of the side effects attributed to the pills were present before the administration, or occurred on placebo medication. His study included a double-blind placebo controlled trial in 398 women, all using foam. The patients were questioned as to nausea, vomiting, headaches, edema, breast tenderness, nervousness, depression, skin discoloration, hair loss or excess hair growth. Only nausea and vomiting seemed to correlate with estrogen level. All the other symptoms were as much placebo-related as pill-related.⁹

In other studies, mood changes varied from 11 per cent, who felt better, to 4 per cent who felt worse.⁸ Libido alterations also vary widely. One study found 32 per cent increased and 8 per cent diminished. However, no alterations or frequency of orgasm has been reported.⁸

Complications of the pill, alleged and observed, include:

Carcinoma: There are at present no findings to establish a carcinogenic effect related to oral contraceptives.^{2, 8} The 10 year latent period, which is now beginning to expire in many patients, may change these findings but as yet no such conclusion is valid.^{2, 8} The cervical changes frequently encountered are reversible upon cessation of the pills. No association with endometrial carcinoma has been established.⁸ Sandmire¹⁰ reported 15,000 consecutive Papanicolaou smears with no increased incidence of cervical carcinoma, among patients on pills.

Chronic cystic mastitis may become aggravated on oral contraceptives, as in pregnancy. This effect subsides upon discontinuation of the pills.⁸

Uterine fibroids may enlarge on oral contraceptives but this effect, probably mainly edema, subsides upon cessation.⁸ In this situation one must reckon with the usual develop-

ment of fibroids in some women which is evolutionary and enlargement will occur over a given period of time, even if uninfluenced by medication (oral contraceptives).

Thromboembolic disorders have been reported in Britain² to be three times higher in users of oral contraceptives than in non-users. They also report² the risk of hospital admission for thromboembolic disease to be 6 to 7 times greater in users. They found the mortality from thromboembolic disease 7 times higher in users. In 1969, a United States study^{2, 11} showed the risk of hospital admission for thromboembolic disease to be 4 to 5 times greater in users than non-users of pills. But a recent study, in Britain,¹² of deaths among young adults showed a 12-fold increase in idiopathic deaths from lung blood clots in a non-pill using population. This report¹² says that in the 15 to 44 age group of women, pill-associated deaths were 3 per 100,000 compared to car accidents 6 per 100,000 and pregnancy/maternal mortality 12 per 100,000.

Since the diminution of estrogen content to 50 micrograms, in the last year, the incidence of thromboembolic disease seems to have decreased. Correlation seems to be with the amount of estrogen. The duration of administration is much less important than the magnitude of the daily dose of estrogen.

Liver effects have been said to be reflected in alteration of liver tests rather than in liver function itself.⁸ The oral contraceptives cause a predictable and reversible fall in hepatic excretory function.¹³ Oral contraceptives will lead to overt liver disturbances with jaundice, when given to patients with inherited or acquired defect in hepatic excretory function.¹³

Thyroid tests are all altered (except the basal metabolic rate) on oral contraceptives. No significant alteration of function has been observed.^{8, 14}

Pituitary effects include suppression of leuteinizing hormone secretion, but no effect on the output of total gonadotropins.⁸

Adrenal effect is that of an increased level of corticosteroid-binding globulin⁸ in the plasma. This effect is not progressive and results in no lack of adrenal responsiveness under stress.¹⁵

Post-pill amenorrhea may commonly occur for 6 to 8 weeks, but may exist longer.⁸ *Fertility* appears to be unimpaired following the use of oral contraceptives, regardless of the number of cycles of use.^{2, 8} In the evaluation of infertility which exists following the use of oral contraceptives one must reckon with the factor of "untested fertility." Long before there were "pills," young women married and controlled their fertility, using the methods then available (condom, diaphragm, spermicide, etc.). After a variable period of time these young women attempted to become pregnant and a certain proportion of them proved to be infertile. Similarly, today, we have young women who have never "been exposed to the hazards of pregnancy," who marry and practice contraception with the use of oral contraceptives. If, later, they prove infertile, the interpretation is made that the infertility is related to or caused by the oral contraceptives. Admittedly, some effect of this nature may occur, but it is equally logical to surmise that a segment of these infertile women had "untested fertility" and would have been found infertile whenever they attempted pregnancy, regardless of whether any or what form of contraception had preceded. While clinical observers appear to agree that most women conceive "promptly" after discontinuation of oral contraceptives and while fragmentary statistics compiled by several investigators are compatible with this impression, hard data are not available.¹⁶

Children born after the cessation of oral contraceptives have no higher incidence of congenital defects.² Fetal masculinization has been alleged in some writings, but not proved.⁸ A Mexican study¹⁷ of 548 pregnancies was recently reported involving 516 women who had been on oral contraceptives. Pregnancies occurred in the first cycle after the pills in 43 per cent and the remaining pregnancies occurred within 19 months. The children

were normal in 96 per cent and the 4 per cent abnormalities included 8 major and 11 minor defects. Compared with a population of similar newborns, before the pill era, there was no statistically significant difference in the ratio of abnormalities.¹⁷

Intrauterine Devices

The modern era of the use of intrauterine devices for contraception came about with the availability of chemically inert materials (plastic, stainless steel, and so on). The sizes, shapes, and material compositions have varied with the imaginations and machinations of the originators. Thus, numerous intrauterine devices are on the market, each with alleged advantages and devoted proponents and users. Today there are 1 to 2 million women with intrauterine devices (IUD) in the United States and 6 million in the world.^{2, 6} Of the users, 70 to 80 per cent still have the IUD after the first year; 60 to 70 per cent after the second year² and 50 per cent still have it after 6 years.⁶ The devices should be inserted during a menstrual period.⁶ Preferably, no anesthesia should be given to allow the patient to warn of exceptional pain and possible perforation.

Contraindications to the insertion of an IUD have variously been quoted to include:

- Previous cesarean section^{6, 18}
- Pelvic inflammatory disease¹⁸
- Recent septic abortion¹⁸
- Old severe septic abortion¹⁸
- At the 6 weeks postpartum examination^{6, 18}
- Nulliparity¹⁸
- Large fibroid uterus⁶
- Acute cervicitis⁶
- Carcinoma of uterus or cervix⁶
- Dysfunctional uterine bleeding⁶
- Polypi (cervical or uterine)⁶
- Blood dyscrasias⁶
- Congenital, rheumatic heart disease, endocarditis⁶ (be cause of the risk of induced subacute bacterial endocarditis)

Insertion of an IUD may be complicated by syncope and severe cramps which generally subside rapidly.^{2, 6}

Mode of action of intrauterine devices is not exactly known. Factors of effectiveness in-

clude: interference with sperm motility; increased tubal motility; endometritis; leucocytic mobilization which affects the survival of the blastocyst *in utero* or acts on the endometrium to render it unsuitable for nidation.⁶

Advantages of the IUD are that it requires no motivation and no intelligence; it is dissociated with sexual relations; and it is suitable for large scale programs.

Effectiveness of the IUD depends on the type and size of the device. The pregnancy rate quoted varies, from 1 to 3 pregnancies per 100 women years.^{2, 6} The rate is lower as the device stays in longer. For some devices up to 11 pregnancies per 100,⁶ 2 to 3 pregnancies per 100, over-all.⁷

Expulsion occurs in 10 per cent in the first year. Inadvertent expulsion is often related to pregnancy.² Expulsion rates as high as 35 per cent are found with certain devices.⁶ *Side-effects*, alleged or experienced, include *bleeding*, intermenstrual or menorrhagic, which usually subsides after 1 or 2 cycles^{2, 6}; *cramps* which usually subside after 1 or 2 cycles. (Persistent, significant bleeding and/or irritating cramps are often the provocative for the patient's demanding the removal of an IUD^{2, 6}); and *pelvic inflammatory disease* which occurs most often in the first month² and in about 2 to 3 per cent of patients in the first year.⁷ The pelvic inflammatory disease can often be treated with bed rest, antibiotics and without removal of the IUD, but not always. At times the inflammatory reaction will not subside with the IUD in place.²

Uterine perforation is usually silent² and occurs in one per 1000⁶ to 2500² insertions. Tietze⁷ found perforations with 9 per 1000 insertions of the "bow" and 0.4 per 1000 insertions of the other devices. When perforation occurs with a closed device, it must be removed at once¹⁵ to avoid tissue strangulation (bowel, omentum, and so on). Perforation with an open device does not require emergency removal.¹⁵

Interference with pregnancy is not substantiated.² There is no evidence that the IUD interferes with the implanted embryo.² If pregnancy occurs with the IUD in place it should be left in place.¹⁸ The fetus can develop normally and the baby, placenta and device will be delivered together. The precipitous removal of an IUD in an early intrauterine pregnancy may abraid the surface of the developing pregnancy and allow the development of a seriously-damaged fetus, if the uterus is not curetted after the IUD is removed.

Ectopic pregnancy occurs in 1 of 20 pregnancies with an IUD.⁶ However, the IUD probably does not increase the incidence of tubal pregnancy.¹⁹ The impression arises because the IUD protects more efficiently against intrauterine than against tubal pregnancy.¹⁹

There is no evidence that the IUD interferes with *fertility* after removal. There is no increase in the incidence of *malformation in children* born after the removal of an IUD.² There is no evidence of *carcinogenicity* related to the IUD.²⁰ *Embedding* of an IUD has been reported and when it occurs bleeding is prominent and removal often difficult.⁶

Surgical Sterilization

Surgical sterilization involves the ligation, cutting or excision of a portion of the fallopian tube or the vas deferens. This method is probably maximally effective.² Failures do occur at times due to surgical error or anomaly. The side effects are the possible complications to the surgical method or anesthesia used to accomplish the result desired. One distinct disadvantage is the probable permanence of the method. Reversibility is conjectural.

At present, a report² states that about 110,000 voluntary sterilizations are done per year in the United States, 65,000 women and 45,000 men.²

Summary

In helping a patient choose a contraceptive method, one must consider carefully the

esthetic suitability to the patient, the safety and effectiveness for that patient, and the possible remote effects of the particular method chosen on the individual involved. Since effectiveness is often the prime consideration, after acceptance and contraindications have been carefully reviewed, it bears repetition to enumerate the order of effectiveness of the non-surgical methods of contraception presently available:

Oral contraceptives: 0.7 to 1.4 pregnancies per 100

Intrauterine devices: 1.5 to 3.0 pregnancies per 100

Rhythm: 6.6 to 14.0 pregnancies per 100

Diaphragm: 10 pregnancies per 100

Condom: 6.0 to 20.0 pregnancies per 100

Spermicides: 28 to 36 pregnancies per 100

Post-coital douche: least effective

Coitus interruptus: least effective

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Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status — urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children — not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



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Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

Loridine® CEPHALORIDINE



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinistest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

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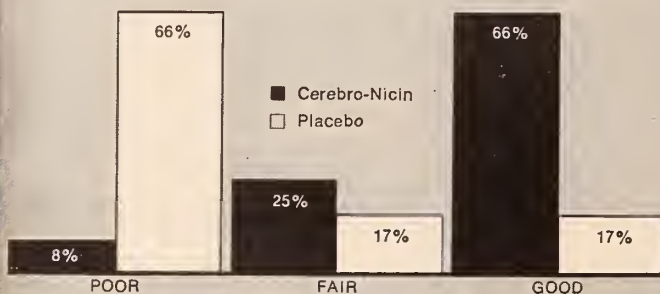
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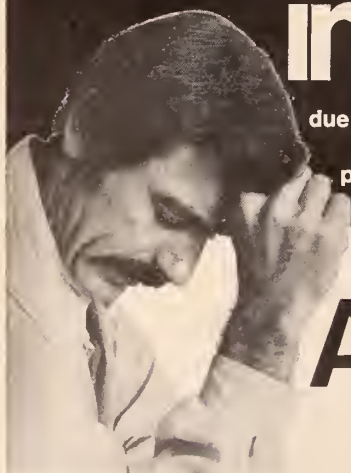
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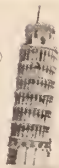


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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary calculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in unimproved patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

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Compared with the LE cell test, the ANA test is found more objective and more sensitive but less specific.

LE Cell Test and Anti-Nuclear Antibody Test in Diagnosis of Systemic Lupus Erythematosus*

**Stanley Burrows, M.D. and
Elizabeth Domako/Camden**

The LE cell preparation is a frequent procedure today because of clinicians' awareness that systemic lupus erythematosus (SLE) is not a rare disease, may present in a bizarre fashion, and may be confused with other collagen diseases. A positive LE cell test requires the reaction of leukocyte nuclei with antibody to DNA-histone nucleoprotein followed by phagocytosis of the altered nuclear material by viable neutrophils.¹ The test is time-consuming and requires careful screening of blood smears by a skilled technologist.

Antibodies to various nuclear components commonly occur in SLE and may be detected by indirect fluorescent antibody technics using nuclei from normal tissues or tumor tissue of human or animal origin. The antibody-antigen reaction is detected by use of a fluorescent-tagged antibody developed in animals with specificity against human immunoglobulins. The fluorescent tag on the animal antibody permits its localization by fluorescent microscopy.

We studied the relative value of the LE cell test and the anti-nuclear antibody (ANA) test in general hospital practice. All blood specimens submitted for either an LE cell test or an ANA test were also checked by the alternate test. No other attempt was made to select the patients. Clinical data were not available until completion of the tests. Each of the two tests was done in a different labora-

tory section. Result of the alternate test was not known until the end of the study. From one to three blood specimens from each of 116 patients were tested by both methods.

The nuclear substrate for the ANA test consisted of acetone-fixed fresh smears of mouse liver. Initial screening was performed with undiluted serum and with serum diluted one to ten with saline. The procedure involved application of the serum specimens to the mouse liver smears for 30 minutes at 37°C, followed by washing and application of diluted rabbit anti-human gamma globulin-fluorescein conjugate for an additional 30 minutes at 37°C. The smears were then washed and examined with a Leitz ortholux microscope equipped with a BG12 exciter filter and K510 (OG10) barrier filter. Fluorescence of the nuclei was considered a positive test. If the screening test was positive, it was repeated with serial dilutions of the test serum to determine the highest dilution that would still give a positive result.

The LE cell test was done by the incubation of a heparinized blood sample at 37°C for 90 minutes followed by concentration of the buffy coat by centrifugation and the microscopic study of stained smears of the buffy coat of leukocytes for LE cells.

Results

Results are summarized in Table 1. The ANA

*This work is from The Cooper Hospital where Dr. Burrows is chief attending pathologist and Elizabeth Domako is chief serologist.

titer varied from 1 to 5 to 1 to 1280 in the eight patients with positive LE preparations and ANA tests.

One patient had negative ANA tests despite 3 positive LE cell tests. This was a 57-year old man who was admitted in congestive heart failure with pulmonary edema, right pleural

Table I
Results of Tests

<i>Tests</i>	<i>No. of Patients</i>
Both tests negative	101
Both tests positive	8
LE negative, ANA positive	6
LE positive, ANA negative	1

effusion, and resolving pulmonary infiltrates. He improved with diuretics and digitalization. Although he was discharged with the diagnosis of probable SLE, this seemed to be based largely on the positive LE preparations rather than clinical criteria or other confirmatory laboratory findings.

Diagnoses in the six patients with positive ANA tests but negative LE tests are listed in Table II. The weakest ANA test occurred in the patient with viral pneumonia with pleurisy, being only weakly positive with undiluted serum only. The patient with rheumatoid arthritis had an ANA titer of 1 to 20. The remaining four patients had ANA titers of 1 to 80 to 1 to 640, the highest titer occurring in the two patients with mild SLE and discoid lupus erythematosus.

Table II

Diagnoses in 6 Patients with LE Negative, ANA Positive

Mild systemic lupus erythematosus
Discoid lupus erythematosus
Rheumatoid arthritis
"Myalgia"
Viral pneumonia with pleurisy
Myocardial infarction with thrombophlebitis

Comment

The LE cell test requires viable leukocytes, detects antibodies against only one nuclear component, is relatively insensitive and cannot be quantitated. In contrast, the ANA test

is more sensitive, objective and quantitative, and detects antibodies against a variety of nuclear antigens without use of viable cells.¹ The greater sensitivity of the ANA test is achieved with some sacrifice of the specificity.² The ANA test is rarely negative in systemic lupus, but false positive results frequently occur in other diseases. The ANA test is almost always positive if the LE cell test is positive.

Of the patients with SLE, 97.7 to 100 per cent have positive ANA tests, usually in high titer.^{3 4 5} Positive ANA tests have been described in rheumatoid arthritis, chronic active hepatitis or lupoid hepatitis, psoriatic arthritis, scleroderma, chronic discoid lupus erythematosus, and collagen vascular disorders. However, very high ANA titers are strongly suggestive of SLE or scleroderma and usually distinguish SLE from chronic discoid lupus erythematosus.⁴ In addition, rising or falling ANA titers in SLE are indicative of increasing or decreasing clinical activity of the disease.

A negative ANA test virtually excludes the diagnosis of SLE,³ except when the patient is in remission or is receiving immunosuppressive therapy such as corticosteroids or azathioprine.² The ANA test may also be indicated for patients who are about to receive medication associated with the precipitation of lupus syndrome, with the recommendation that these drugs should *not* be given if the ANA test is positive or should be stopped if the ANA test becomes positive after the drug has been started.⁵

Our own experience indicates that an occasional case of SLE (particularly if early or mild) may be missed if reliance is placed only upon the LE cell test. The ANA test will very likely be positive in such a case, but its lack of specificity must also be appreciated in the final correlation with clinical findings and other laboratory tests. A high ANA titer adds greater specificity to its evaluation and in gauging disease activity. The routine performance of both the LE cell test and the ANA test rather than only one test offers the greatest diagnostic information.

Summary

A comparison of the LE cell test and the ANA test in 116 patients confirmed the greater sensitivity but reduced specificity of the ANA test in the diagnosis of SLE. The ANA test is more objective and its quantitation offers additional diagnostic value. The performance of both the LE cell test and the ANA test is recommended for greatest diagnostic potential.

The Cooper Hospital

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Peer Review and Federal Controls

The administration has asked Congress for tighter government control over any peer review setup for medicare and medicaid than would be provided by the Bennett amendment approved by the Senate in 1970. To the House Ways and Means Committee, Secretary Richardson explained:

"We agree with the objective of assuring an expanded role for the medical profession in peer review activities and recognize the need for improvement of utilization review procedures. However, certain modifications in the senate provisions would be desirable. We do not think that the secretary of HEW should be required to use medical-society sponsored groups in situations where there may be a highly qualified review organization in the area that has already demonstrated its ability to perform well. We favor giving the secretary greater flexibility to permit, through regulations, variations in the structure and patterns of operation of peer review groups."

Richardson was testifying on H.R. 1 of the 92nd Congress. The social security measure includes provisions for peer review. Both chambers of Congress passed such legislation last year but the senate added so many amendments to the house-passed bill that congressional leaders decided it would be futile for a house-senate conference committee to try to reconcile the differences. The house

committee made the legislation the first order of business this year.

Richardson again asked for authority to use health maintenance organizations (HMO's), or prepaid group practice, for the government programs. He wanted authority to limit physicians' fees under medicare. Both provisions were approved in varying forms by the House and Senate last year. "We believe" said Mr. Richardson, "that HMO's can help solve many of the problems facing the health care system today—the uncontrolled rise in health care cost, over-utilization of high cost services, improper allocation of resources, inadequate emphasis on preventive care, and inefficient use of available health manpower. Encouragement of HMO's may be the most important step we can take to stimulate the restructuring of the health delivery system. We believe that there can be significant long-run savings in program costs due to the HMO option."

Concerning the proposed limitation on increases in physicians' fees, Richardson said:

"We believe that if recognition of fee increases is tied to appropriate economic indexes, this will help to assure that the recognition of such increases is appropriately related to developments in other pertinent sectors of the economy."

Guide his hand to quality and economy

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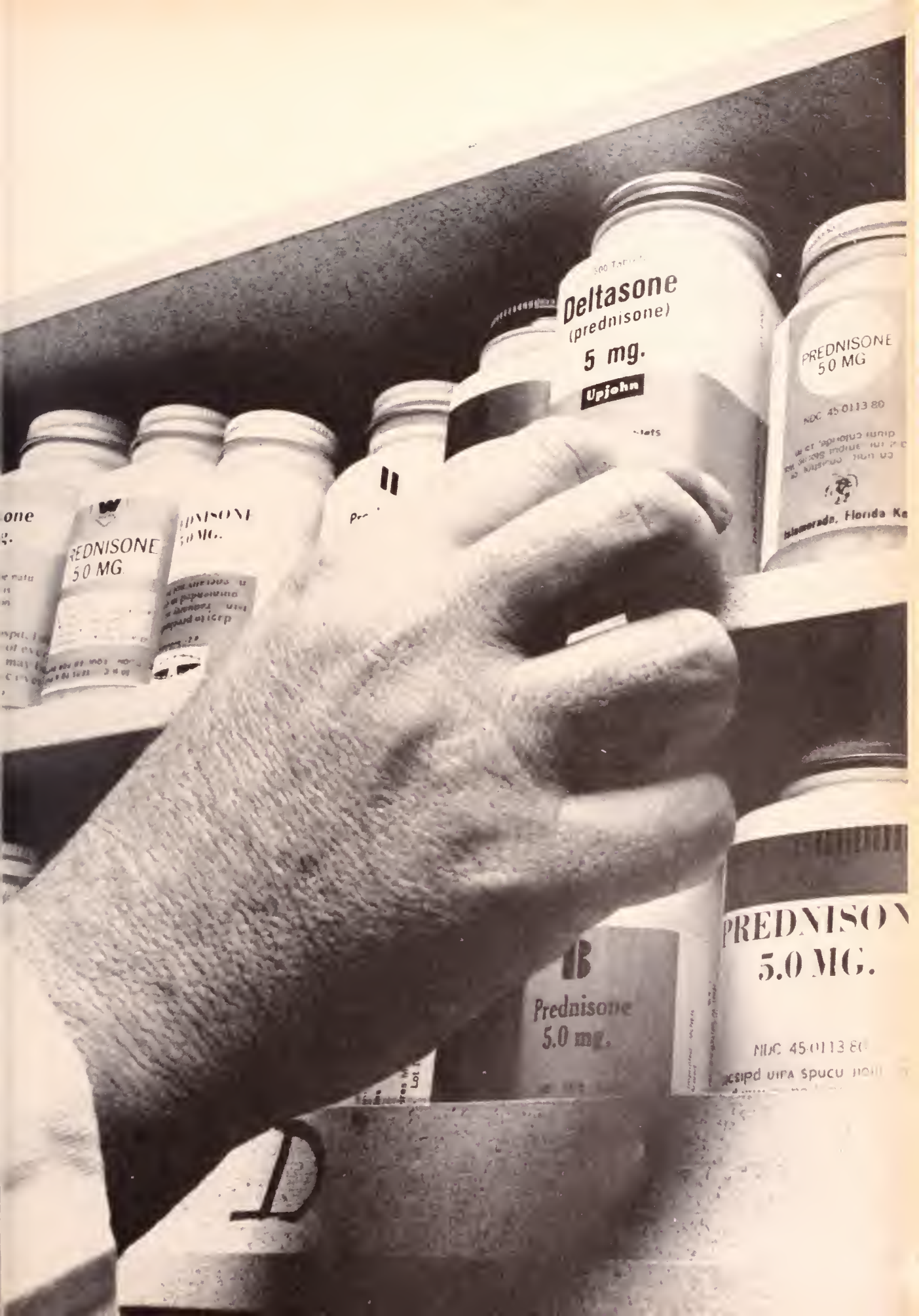
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The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. **Important:** Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccination, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance

doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9- α -fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoid during pregnancy, since spontaneous remission of some disease such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis an ulcer regimen and antacid are highly recommended. Take X-ray in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

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Selective conservatism is here explained as a criterion for selecting operative subjects in abdominal trauma.

The Rational Approach to Abdominal Trauma*

Gerald W. Shaftan, M.D.
Brooklyn, New York

We believe that any well trained surgeon can safely select those patients with penetrating abdominal trauma who require surgical exploration.

In 1749, Hunter noted that, "This last part of surgery, namely operation, is a reflection on the healing art. It is a tacit acknowledgment of the insufficiency of surgery. It is like an armed savage who attempts to get by force that which a civilized man would get by stratagem. No surgeon should approach the victim of his operation without a sacred dread and reluctance."

Some three thousand years before Hunter, in the Edwin Smith Papyrus, our oldest surgical text, the surgeon was advised in the various case reports to make one of three diagnoses. The first, "an ailment which I will treat;" the second: "an ailment with which I will contend;" and the third, "an ailment not to be treated." The importance of these diagnostic divisions can be gleaned from the earlier *Coda Hammurabi*, which while prescribing a generous fee for the successful treatment of a wound also required that the surgeon have his hands cut off if the patient were to lose his life as a result of treatment.

The Edwin Smith Papyrus does not list any cases of abdominal trauma but certainly, had they been reported, they undoubtedly would have been included in the untreatable category, for Hippocrates, a thousand years later, notes that a "severe wound of the bladder . . .

of the small intestine, of the stomach, and of the liver is deadly."

Celsus, in ancient Rome, was more optimistic. In abdominal injuries, he advocated suture of the intestine when it was the large intestine that was damaged but noted that there was no hope of cure when the small intestine was injured. This pessimistic approach toward abdominal trauma continued well into the eighteenth century, despite the demonstration by Baudens in 1830, that one of two patients explored with a gunshot wound of the abdomen survived operation. This surgeon, during the Crimean War, advised the introduction of a finger or a small sponge into the enlarged abdominal wound. If blood, feces, or bubbles were present he advocated "bold operation"—in their absence he recommended abstention. Despite Baudens' experience, the standard treatment for abdominal wounds until the late nineteenth century was rest, opium, dressings, protection of the wound, and, of course, frequent bleeding or venesection. By 1887, with Marion Sims in the lead, the majority of the American Surgical Association expressed the opinion that operative treatment of penetrating abdominal trauma was consistent with the advances made in other areas of intraperitoneal surgery. At the start of the Boer War, surgical intervention of penetrating abdominal injuries was advocated by the British.

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Unfortunately, mortality during the first year of that war was significantly higher among those operated upon than those treated by careful studied neglect. Thus, ultraconservative approach to penetrating abdominal trauma had sound statistical basis and continued for the first fifteen years of the twentieth century. The number and magnitude of abdominal injuries and a 90 per cent mortality from failure to repair the injured structures during the first two years of World War I necessitated a change to mandatory routine abdominal exploration and repair. This lowered the death rate to 53 per cent. The subsequent improvement in mortality statistics to 25 per cent in World War II, 12 per cent during the Korean police action, and 9.6 per cent during the current Viet Nam conflict, has reinforced the military precepts of mandatory abdominal exploration for penetrating abdominal wounding. Nevertheless, this policy of uniform celiotomy for penetrating abdominal trauma (which arose out of and is maintained because of military necessity) persists unnecessarily into post-war civilian practice.

Our original study was prompted by a death, following celiotomy for an abdominal stab wound which did not penetrate the peritoneal cavity. As a result of postoperative complications, which included delirium tremens, evisceration, and peritonitis, we reviewed all patients with abdominal trauma treated on the University Surgical Service of the Kings County Hospital Center in 1952, 1953, and 1954. One hundred and thirty-three patients were characterized according to type of trauma. Almost three quarters of these patients had penetrating type injuries. Surprisingly, only one-half of the patients with stab wounds were explored despite the Service policy requiring mandatory exploration of these wounds. Patients were divided into three groups: Group A were patients who had evidence of intraperitoneal injury at operation or autopsy, Group B were those treated without operation, and Group C comprised the patients who underwent celiotomy without findings of intra-abdominal injury. None of the patients in Group B or C (that is, those

who were *not* operated upon or who had negative explorations) had generalized direct or rebound tenderness, abdominal muscular spasm, or absent bowel sounds. In the main, these patients had no abnormal abdominal physical findings. Therefore, if the ordinary criteria for an acute surgical condition of the abdomen had been used, exploration would have been avoided in all the patients in Group C.

Table I

*Indications for Abdominal Exploration
in Abdominal Trauma*

1. Signs of peritoneal irritation
 - a. Direct tenderness
 - b. Rebound tenderness
 - c. Abdominal wall spasm
 - d. Persistent hypoactive or absent bowel sounds
2. Positive peritoneal aspiration and/or lavage
3. Persistent unexplained shock
4. Ancillary signs
 - a. Radiographically demonstrable intraperitoneal air
 - b. Hematemesis
 - c. Proctorrhagia

As a result of this early retrospective study, certain criteria were evolved for selecting patients for abdominal exploration and we have termed this method of management, selective conservatism. (See Table I) The primary indications were signs of peritoneal irritation—that is, direct and rebound tenderness, abdominal wall spasm, and persistent hypoactive or absent bowel sounds. These signs are also used in evaluating the need for abdominal exploration for intraperitoneal inflammation. The loss of bowel sounds, in particular, has proved to be the most useful index for abdominal exploration and (except in shock) usually indicates intraperitoneal injury. While in most patients the need for exploration is obvious on admission, where immediate decision cannot be made it is necessary to repeat the clinical evaluation at frequent intervals, every half hour shortly after admission and gradually lengthening the interval as security in patient observation increases. This prolonged observation is the most difficult aspect of selective conservatism. Alteration of the physical signs indicating increased peritoneal irritation demands imme-

diate exploration while a decrease in findings correspondingly permits increased confidence in the nonoperative management.

Exploratory paracentesis has gained recognition as a simple and accurate diagnostic accessory to abdominal evaluation. In abdominal trauma, especially in blunt abdominal trauma, it can be invaluable. The positive peritoneal tap is always an indication for immediate abdominal exploration. The negative paracentesis has absolutely *no* prognostic value. Root¹ has indicated his preference for diagnostic peritoneal lavage as the primary step in the evaluation of abdominal trauma. In most instances, simple paracentesis will supply as much information as may be obtained from peritoneal aspiration but where the former does not provide a definitive answer, we immediately proceed to peritoneal lavage. For this reason we now use the four inch long, fifteen gauge Teflon® needle with multiple end side holes and a short bevel obturator (Becton-Dickinson #01-0049) for routine exploratory paracentesis. Since the needle itself is flexible we utilize a single insertion, rather than the two or four quadrant taps formerly advocated. The needle may be moved around within the peritoneal cavity and the patient positioned to obtain maximum yield. If paracentesis is not productive, 1,000 milliliters of 1.5 per cent Dianel® or saline is instilled through the same cannula and an aliquot aspirated for examination. Grossly bloody, bile stained, or turbid fluid or even microscopic red and white blood cells is sufficient indication for celiotomy.

Shock, which is persistent, unexplained by external blood loss, especially with blunt abdominal trauma, is an indication for exploration. The peritoneal cavity and the retroperitoneum provide the only area in the body in which large quantities of intravascular volume may be sequestered. X-ray evaluation is of value for the localization of missiles but an occasional patient has been operated upon for the presence of intraperitoneal free air. Free air is a rare finding on routine chest film and has occasionally been noted unassociated

with intraperitoneal viscus injury, nevertheless, its presence makes abdominal exploration mandatory. Additionally, blood in the stomach, hematemesis, proctorrhagia, or blood on the examining rectal finger are ancillary signs indicating the need for abdominal exploration. Patients who are not explored immediately must have abdominal paracentesis or lavage and radiographic studies of the chest and abdomen performed as routine measures.

Since 1956, we have used these indications in all types of penetrating abdominal trauma as well as in blunt abdominal trauma in the selection of patients for exploratory celiotomy. The following results, therefore, are of a prospective on-going study. We are in the process of reviewing our results through 1969. The last completed review was in 1964. The figures here reported represent 535 patients with penetrating wounds of the abdomen seen by the Trauma Service of the Kings County Hospital Center from January, 1956, through June, 1963, handled under this policy of selective conservatism.

Patients ranged in age from 5 to 100 years; there were 461 males and 74 females. The highest incidence was in men in the third decade of life. Four hundred and seventy-seven patients were stabbed, fifty were shot, and eight had miscellaneous wounds. More than 20 per cent of the patients were drunk at the time of initial examination. One hundred and twenty-nine patients were explored because of one or more of the previously noted signs; twenty-one additional patients were explored despite the absence of these indications. By contrast, none (except one) of the non-operative group manifested any of these criteria for operation.

Abdominal aspiration, particularly in recent years, has added immeasurably to our diagnostic acumen. Paracentesis was performed and recorded in 17 per cent of the present series. A positive peritoneal aspiration was obtained in 25 patients. Nine of these patients had positive paracentesis as the sole indication for abdominal exploration. While

Table II
Penetrating Abdominal Trauma
(Figures in parenthesis indicate mortality)

<i>Type of Injury</i>	<i>Died before Treatment</i>	<i>Non-operative</i>	<i>Operative</i>	<i>Total</i>
Stab	1 (100%)	361 (0.5%)	115 (6%)	477 (2%)
G S W	0 (0%)	17 (0%)	33 (12.1%)	50 (8%)
Other	0 (0%)	6 (0%)	2 (0%)	8 (0%)
Total	1 (100%)	384 (0.5%)	150 (7.3%)	535 (2.6%)

most of them developed peritoneal signs during the interval from the original examination to operation, the utilization of this diagnostic procedure did permit earlier exploration and, possibly, reduced morbidity. A single instance of false positive paracentesis was experienced.

The use of radiography was of lesser importance; only three of the one hundred and fifty patients explored demonstrated free intraperitoneal air on roentgenographic examination of the abdomen. Its value, however, should not be negated by the poor yield, since one patient was selected for exploration merely on the radiographic demonstration of free intraperitoneal air. This patient also developed the signs of peritoneal irritation in the interval from examination to operation. Free subdiaphragmatic air was demonstrated in another patient without other abdominal signs. No intraperitoneal injury was found at celiotomy, suggesting the entrance of air through the abdominal wound at the time of injury.

Evisceration of omentum through the penetrating abdominal wound is a strong psychological impetus for surgery. Eleven of 25 patients with omentum protruding from the abdominal wound had celiotomy for the presence of the protruding omentum alone, without signs indicating the need for exploration. All eleven had negative explorations. Eight patients, who also lacked the criteria for celiotomy, had the omental protrusion pulled up, ligated and returned to the peritoneal cavity. All eight did well. The remaining six patients with omental herniation had peritoneal signs in addition to protruding omentum and were explored. Celiotomy was necessary in each on the basis of operative findings.

Ten patients without signs of peritoneal irritation were explored "routinely"—that is, because of the presence of a penetrating type of abdominal wound only, without regard for the criteria mentioned previously. This deviation from our established policy is attributable to the personal references of a few attending surgeons. All ten had negative explorations.

Three hundred and eighty-four patients, or 72 per cent of the entire series, were treated without abdominal exploration. (See Table II) These patients did not have any indication for exploration and did well with frequent careful observation. There were two deaths in this group. One death resulted from head trauma; no abdominal injury was found at autopsy. The other death was in a patient stabbed in the left chest and upper abdomen who was erroneously treated conservatively despite a positive peritoneal aspiration. He died suddenly on the seventh hospital day. Autopsy revealed splenic laceration with old clotted hemoperitoneum and hemothorax without evidence of recent bleeding. Adherence to the established criteria, however, should have prompted exploration in this case and possibly would have avoided this fatal outcome.

Seventeen patients with gunshot wounds of the abdomen were not explored. While a tangential trajectory through the abdominal wall could have been postulated in some instances, the decision to treat these patients expectantly was based only on the absence of peritoneal signs. One hundred and fifty patients (28 per cent of the series) had abdominal exploration. All of the 33 bullet wounds explored had an indication for celiotomy; none were explored "routinely." Forty-four patients had no surgical repair at exploration. Twen-

ty-one of these "unnecessary explorations" had indications for operation but the intra-abdominal injury, primarily nonbleeding hepatic wounds or retroperitoneal hematomas, did not necessitate repair. The remaining twenty-three patients had negative explorations; twenty-one of these were explored routinely or for the presence of omental herniation alone; one had a peritoneal aspiration that was falsely positive; and one had free intraperitoneal air demonstrated radiographically.

One patient arrived in the Emergency Room following abdominal stabbing without obtainable pulse or blood pressure. He died shortly thereafter despite vigorous attempts at resuscitation. The two deaths in the non-operative group have been noted.

The over-all mortality for the 535 patients in this study was 2.6 per cent. The mortality was 0.3 per cent in those patients treated by selective conservatism. Eleven patients (7.3 per cent) in the operative group died, 7 among the 115 stab wounds and 4 of the 33 gunshot wounds that were explored. None of these patients died because of delay or failure to recognize the need for abdominal exploration. Mortality, including the patient who died before operation, the death from head trauma, and the patient erroneously treated conservatively, was 2 per cent of the 477 patients with stab wounds.

The value of selective conservatism also depends on the absence of significant morbidity. There were complications in only thirteen patients (3.3 per cent) of the 384 treated conservatively, contrasted to 46 patients (31 per cent) with morbidity in the operative group. There were four serious complications in those 21 explored either routinely or for the presence of protruding omentum alone.

Since Cornell's report² in 1965, the instillation of radiopaque media into the penetrating wound for x-ray confirmation of intraperitoneal perforation has gained considerable popularity. Its primary importance is demonstrating that the nonoperative ap-

proach is feasible in many patients with civilian penetrating type injuries. Unfortunately, the technic is time-consuming, painful, and thereafter obviates the exercise of surgical judgment because of the abdominal wall pain and muscle spasm produced by drug irritation. Moreover, mere penetration of a peritoneal cavity is insufficient reason for abdominal exploration since the intraperitoneal injury may be slight or nonexistent. In addition, failure to demonstrate peritoneal penetration by dye instillation would give us a false sense of security. Many of our patients have combined penetrating and blunt abdominal trauma and the negative dye study might cause us to forget the difficulty in diagnosis and the high mortality associated with blunt injuries.

A recent study by Weil and Steichen,³ comparing surgical evaluation with radiopaque dye instillation, showed 54 per cent fewer negative explorations with the clinical technic advocated by us with no errors in diagnosis. We are completely satisfied with our clinical approach in selecting patients with penetrating abdominal trauma for operation, experiencing a low mortality and the lowest over-all morbidity reported in the literature. Our experience is not unique. Others have used selective conservatism in the management of abdominal stab wounds and have noted the accuracy of the criteria for exploration. They have experienced no mortality and decreased morbidity in the conservative therapy group. It is difficult, however, to compare results from different institutions. For this reason the paper by Nance and Cohn⁴ detailing their experience with the clinical technic and contrasting it to the mandatory exploration study reported from the same hospital by Moss, Schmidt, and Creech⁵ is a classic report. Their lowering of morbidity from 27 to 12 per cent without an error in diagnosis reinforces our conviction that sound surgical judgment based on standard clinical evaluation is a reliable means of selecting patients for operation in abdominal trauma. While these authors did not treat gunshot wounds by selective operation, there is no reason to expect that a sharp knife inflicts less damage

than a dull, low velocity bullet. The proponents of routine celiotomy rarely suggest that routine exploration be utilized for blunt abdominal trauma; yet blunt abdominal injury is more difficult to diagnose and has a higher over-all mortality than trauma of the penetrating type.

Confidence in the reliability of criteria for exploration has prompted us to explore only 28 per cent of our patients with penetrating wounds of the abdomen, lower than the operative ratio of any series. It is unfortunate that the single death in the stab wound group (though improperly treated) now prevents us from stating again that we had no significant morbidity or mortality by following a policy of watchful expectancy. With frequent observation and evaluation of findings we still feel that the established criteria for exploration are valid and the risk in awaiting development of indications for celiotomy is minimal. Our mortality for all penetrating abdominal wounds (2.6 per cent) is lower than the mortality of any comparable series in the literature.

Selective conservatism would not be justified, however, were there no danger in routine exploratory celiotomy. Moss, Schmidt, and Creech⁵ in their review of 550 stab wounds of the abdomen treated by routine exploration had a morbidity of 33 per cent. Nearly one half of these complications were in patients who required no treatment at exploration. Our own morbidity of 23 per cent in patients with negative explorations confirms this risk. Wilson and Sherman,⁶ moreover, had one mortality following a negative exploratory celiotomy and Maynard⁷ reports 5 deaths

among 79 negative explorations which amounts to 6.3 per cent.

Nance⁴ notes that allowing the use of surgical judgment has made it more difficult for the surgeon since each patient must be evaluated separately and observed patients must be followed carefully and conscientiously like any other critically ill surgical patient. The reduction of unnecessary operations and the marked decrease in over-all morbidity more than makes up for the increased difficulty the surgeon must bear. As surgical experience throughout the country increases, it becomes obvious that the war-time expediency of routine exploration for penetrating wounds of the abdomen is not justified in civilian practice. Certainly, when adequate facilities for the careful observation and investigation of these wounded patients are available, superior mortality and morbidity statistics can be expected by judiciously selecting those patients requiring exploratory celiotomy. Routine exploration is a dogma no longer valid for civilian penetrating abdominal injuries.

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Recent Experiences with Gallstone Ileus*

Hans Vejlsted, M.D., et al./Princeton

Gallstone ileus is a rare form of intestinal obstruction—so rare that one clinician cannot expect to see more than one or two cases in a lifetime. Hence it seems appropriate to report here three instances of gallstone ileus occurring in two patients within a two-month period.

Case One

A 65 year old epileptic and long-term resident of the New Jersey Neuropsychiatric Institute was admitted with a five-day history of abdominal distention and vomiting. Treatment prior to admission consisted of intravenous fluid and Miller-Abbott tube suction. Because of her emotional illness, no previous history could be elicited. She was an obese, slightly dehydrated woman with a distended abdomen. Small bowel obstruction was apparent on review of the abdominal x-rays.

She was explored by one of us (JBH) through a low midline incision. A large acute inflammatory mass was felt in the area of the gallbladder. At least one stone was palpable in the gallbladder, and there was a faceted gallstone impacted in the distal ileum. The stone in the ileum was removed through a small enterotomy and the wound closed. Because of the patient's condition and the inflammation present in the gallbladder, it was elected to reserve cholecystectomy for another day. Retrospective examination of the x-rays revealed air in the biliary tree. She did well until four days after the operation when she developed another episode of mechanical obstruction.

At reoperation a second gallstone was found impacted in the ileum at the same location as in the first episode of gallstone ileus. The stone in the ileum was removed; cholecystectomy was accomplished; and the cholecysto-duodenal fistula was closed. Postoperatively she developed *Klebsiella* infection in the wound which was treated by drainage. The patient returned to the Institute in a satisfactory condition 25 days after admission.

Case Two

A 78 year old woman was admitted with a 36-hour history of nausea, vomiting, and epigastric pain. She furnished a three-day history of abdominal distention and anorexia preceding the abdominal pain. Additional history (obtained later) included a record of gallbladder attack 20 years ago and a history of vomit-

ing gallstones 11 years ago. At that time the patient had refused further treatment.

We now saw a dehydrated woman with abdominal distention and no signs of localized peritoneal irritation. Roentgenograms indicated moderate small bowel distention, small aortic aneurysm, and calcification in the splenic artery.

During the 36 hours after admission she developed minimal ascites, although her condition improved with intravenous fluids and electrolytes. Pain had subsided. On the fourth day after admission she again had abdominal pain, as well as tenderness in the mid-abdomen. Upon operative exploration by one of us (JJC) for suspected mesenteric vascular occlusion, there was found moderate ascites. A 5.3 by 3.0 cm. non-faceted gallstone was found impacted in the distal ileum. This was removed with the longitudinal incision being closed transversely on the anti-mesenteric border. The empty thick-walled gallbladder was noted to be fused to the duodenum. The operation was terminated with closure of the abdomen.

Diagnosis of gallstone ileus is usually difficult, and this leads to delayed operation. In the first case, here reported, history was impossible to elicit. In the second case, the patient reported symptoms of cholecystitis and several days after the operation volunteered the information of past emesis of gallstones.

Buetow *et al.*¹ discussed recurrent gallstone ileus and emphasized the 5 per cent early post-operative recurrence rate due to stones left behind during the first operation. When a faceted stone is found, especially, the gallbladder and remainder of the bowel should be searched for other stones.

Holz² and Welch, *et al.*³ published reports of a one-stage cholecystectomy and closure of the cholecystic-enteric fistula combined with removal of the obstructing stone in the small

*From the Departments of Surgery and Medicine, Princeton Hospital, Princeton, New Jersey. Co-authors are James B. Hastings, M.D., William F. Haynes, M.D., and James J. Chandler, M.D.

bowel. Although several other authors have more recently emphasized the usefulness of primary repair of the fistula with one-stage treatment of gallstone ileus, only 20 cases of this type of approach were reported throughout the year 1968.⁴ In an ill patient with complicated dissection necessary for primary repair, most would advocate simple removal of the obstructing stone and closure of the intestine. Planned full diagnostic studies with a second-stage procedure as indicated would seem a wise choice. Indeed, this was the election taken in our Case 1. However, to the dismay of the operating team, gallstone ileus occurred again on the fourth postoperative day. A complete operative attack on the problem was then carried out and was well tolerated by the patient.

Since a third of the patients whose gallbladders have not been removed (and whose fistulas have not been closed) experience future complications, we would ordinarily recommend elective cholecystectomy and fistula closure in these patients. Our second patient, 78 years old, refused further operation.

A word should be said about diagnosis of gallstone ileus. The symptoms can be those of typical cholecystitis attack or those related to

passage of the gallstone along the intestinal tract. With large stones intestinal obstruction then occurs with attendant vomiting, distention, and hyperperistalsis. Occasionally these patients can be diagnosed correctly preoperatively by noting air in the common duct or bile ducts in conjunction with x-ray evidence of ileus or obstruction. Rarely, the calcified stone will be evidenced in the intestine.

Summary

Three cases of gallstone ileus occurring in two patients during a two-month period during the summer of 1970 are reported. One of the patients illustrates the problem of recurrent gallstone ileus. In the other patient, diagnosis preoperatively could possibly have been made had the patient been interrogated more vigorously and specifically. Both patients are alive and well today.

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(Reprint requests to James J. Chandler, M.D.)

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Milk-of-Calcium Renal Stone*

A Case of Spontaneous Diminution

Joseph J. Seebode, M.D., et al./Newark

Milk-of-calcium renal stone is a rare condition in which tiny calcified particles are loosely suspended in the urine contained within a pyelogenic cyst. The suspension flows freely, maintaining a horizontal fluid level regardless of the patient's position; this can be demonstrated radiographically. We have found only fourteen cases¹⁻¹³ of the condition reported but no mention of any spontaneous disappearance or reduction in size of the stone (suspension). This is a case report of a patient in whom milk-of-calcium renal stone (a finding incidental to a diagnosis of chronic low back pain) spontaneously diminished.

A 25-year-old, mentally retarded male was admitted for work-up of a chronic low back pain. Examination disclosed several congenital anomalies including hypospadias, bilateral undescended testes, bilateral opacities of the posterior lenses and corneae, and bilateral aniridia. Hemogram, blood chemistry, fasting blood sugar, and urinalysis were normal. Chest x-ray revealed a right azygos lobe. Electrocardiogram showed an incomplete right bundle branch block, a normal variant. Antero-posterior and lateral x-ray projections of thoraco lumbar and lumbo-sacral regions of the spine were within normal limits. His backache was initially thought to be "conversion hysteria," but roentgenograms of the spine revealed two extra-skeletal calcific densities. These findings prompted further examination.

*This work is from the Division of Urology at the Martland Hospital Unit of the College of Medicine and Dentistry of New Jersey at Newark. Coauthors are M. H. Kamat, M.D., Instructor in Surgery, and L. R. Hanks, M.D., Chief Urology Resident. Dr. Seebode is the Director of the Division of Urology.



Figure 1A—Plain film of abdomen in supine position shows two rounded calcific densities, one in the region of the gallbladder and the other in the region of the right kidney.



Figure 1B—Plain film of the abdomen in upright position showing that the calcific density in the region of the right kidney has assumed a semi-lunar shape. This is the milk-of-calcium renal stone.



Figure 1C—Oral cholecystogram in upright position. The semi-lunar shadow outside the gallbladder is the milk-of-calcium renal stone.

Plain films of the abdomen in supine and upright positions, an excretory urogram, and an oral cholecystogram (Figure 1) revealed a radio-opaque gallstone and a milk-of-calcium renal stone in the right kidney. Follow-up roentgen studies done three years later (Figure 2) revealed a marked spontaneous reduction in the milk-of-calcium renal stone.



Figure 2A—Plain film of the abdomen three years later showing a marked diminution in the size of the milk-of-calcium renal stone.



Figure 2B—Excretory urogram confirms the location of the milk-of-calcium renal stone to be in the mid-portion of the right kidney.

tion in the milk-of-calcium renal stone.

As shown in Figure 2, the milk-of-calcium stone in our patient showed a marked reduction in its size within three years. As far as we know, this is the first finding of a spontaneous reduction of such a stone (suspension). This reduction probably resulted from recanalization of the obliterated communication between the pyelogenic cyst and its adjacent calyx, with subsequent drainage of some of the particles from the cyst.

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69 Bergen Street

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

Two regular meetings of the Board of Trustees were held during the 1971 Annual Meeting in Atlantic City. Detailed minutes of these meetings are on file with the secretary of your component society. Below is a compilation of significant actions.

May 14, 1971

Emergency Department Nurses . . . Approved cosponsorship with the New Jersey Nurses' Association of a training program for Emergency Department Nurses (to be funded by the Division of Emergency Health Services).

AMA Council on Environmental and Public Health . . . Received, as informative, a report from Dr. Roslyn Barbash on the meeting of the AMA Council on Environmental Health and directed that the report be made available to the members of MSNJ's Committee on Environmental Health.

Governor's Conference of the 70's . . . Received, as informative, the report of the Governor's Conference of the 70's, submitted by Dr. Louis F. Albright.

Solicitation of Convention Funds . . . Disapproved a recommendation contained in the Convention Manager's report on the Conference on Medical Conventions that solicitation of convention funds by MSNJ be discontinued.

Minimum Eye Examination Rules . . . Directed that the proposed Minimum Eye Examination Rules of the State Board of Medical Examiners, setting down 15 steps that must be followed in performing an examination of a patient's eye, be referred to Reference Committee "G" (The Board was informed that two resolutions have been introduced for consideration of the House of Delegates relating to this proposal.)

Proposed Degree Designation Rule . . . Noted a proposed new State Board of Medical Examiners rule on degree designation which states that "a physician licensed to practice medicine and surgery in the State of New Jersey shall identify himself only by that degree designation (M.D. or D.O.) which is imprinted on the license issued to said person."

Health Care Administration Board . . . Agreed to submit the name of Frank J. Hughes, M.D. of Camden to Governor Cahill as a nominee to serve on the Health Care Administration Board, called for by the enactment of S-2088.

Retiring Members of the Board . . . Gave a rising vote of appreciation to Nicholas A. Bertha, M.D., Thomas C. DeCecio, M.D., and Jerome G. Kaufman, M.D. on their retirement from the Board of Trustees.

May 19, 1971

Introduction of New Members . . . Welcomed Dr. George L. Benz, of the 1st District and Drs. Richard E. Lang and James S. Todd of the 2nd District as new members of the Board of Trustees.

. . . Noted that Dr. Lang was elected to fill the unexpired term of Dr. James A. Rogers, who resigned following his election as 2nd Vice-President; that Dr. Nicholas E. Marchione was re-elected to serve from the 5th District; that Dr. Louis F. Albright was re-elected to the office of Secretary; and that Dr. Samuel J. Lloyd was re-elected to the office of Treasurer.

Reorganization of Board . . . Elected A. Guy Campo, M.D. as Chairman of the Board for 1971-72; re-elected George E. Barbour, M.D. as Secretary of the Board for

1971-72; agreed to continue meeting regularly on the third Sunday of each month in the Executive Offices (meetings subject to cancellation should the agenda prove insufficient); re-elected Nicholas E. Marchione, M.D. as a Board of Trustees member on the Finance and Budget Committee (3 year term—1971-1974); elected I. Edward Ornaf, M.D. as a Board of Trustees member on the Finance and Budget Committee (2 years—1971-1973—to fill unexpired term of Thomas C. DeCecio, M.D. who is no longer eligible, having served three consecutive terms on the Board of Trustees).

Reappointment of Salaried Personnel . . . Reappointed for 1971-1972, at the salaries set forth in the adopted budget, all salaried personnel not under individual contract.

. . . Commended the staff and recorded its appreciation and gratitude for the success of the 1971 Annual Meeting.

Fluoridation . . . Directed that Resolutions #1 and #25, urging enactment of legislation obliging the Department of Environmental Protection to promulgate regulations requiring the fluoridation of public water supplies, be referred to the Council on Legislation for implementation.

Automated Bookkeeping and Billing System . . . Directed that a recommendation from Reference Committee "B," that a further survey of counties be taken informing them of the cost factors involved and the advantages of an automated bookkeeping, accounting, and billing system, be referred to the Ad Hoc Committee on a Statewide Automated Bookkeeping, Accounting, and Billing System.

. . . Directed further that this item be placed on the agenda for the Fall Conference of Presidents (of County Medical Societies) and that relevant materials be supplied to the counties for consideration in advance of this Conference.

AMA System of Coding and Nomenclature . . . Directed that a letter, over the signature

of the Secretary of the Board of Trustees, go to the Medical-Surgical Plan of New Jersey and to the fiscal intermediary for Medicare and Medicaid recommending that they consider adopting the AMA system of coding and nomenclature as the universal system for description of medical services. (This is in accordance with the House action on Resolution #27.)

Internships and Residencies in New Jersey Hospitals . . . Directed that consideration of Resolution #44 be tabled until the July meeting of the Board.

Interns' and Residents' Power to Sign Certain Legal Documents . . . Directed that a letter go to the Secretary of the State Board of Medical Examiners asking for further clarification of the 1970 opinion from the Attorney General that prescriptions signed by interns and residents of the Martland Medical Center in Newark may be legally filled in retail pharmacies—in all other areas of the State this privilege does not apply.

Immunity for Physicians Making Blood Alcohol Determinations . . . Directed that Resolution #8, which seeks enactment of legislation to provide physicians with immunity from litigation arising from compliance with the request of a law enforcement officer for a blood alcohol determination, be referred to the Council on Legislation.

Blood Transfusing Is a Service Not a Sale . . . Directed that Resolution #10 which urges enactment of S-752 (to provide that blood, blood plasma, tissues, or organs should not be considered commodities subject to sale or barter) be referred to the Council on Legislation.

Eye Medication Ruling . . . Directed that Resolution #12, calling for the introduction of legislation to prevent optometrists from using eye medication for diagnostic purposes, be referred to the Conference Committee on the Control of Eye Medication for early consideration, and that, upon receipt of a report from that Committee, Resolution #12 then

be referred to the Council on Legislation for the preparation of an appropriate bill for introduction into the Legislature.

Legislative Approach to Professional Liability . . . Directed that the President be empowered to appoint an *ad hoc* committee as called for in Resolution #24 (which is concerned with the introduction of legislation involving matters of professional liability).

Criteria Used by Fiscal Intermediaries in Reviewing Physicians' Services . . . Directed that a letter go to the fiscal intermediary (Medicare and Medicaid) requesting that physicians be notified directly and promptly of any changes in policy by the fiscal intermediary. (In accordance with a House approved request from Reference Committee "F".)

Approval Criteria of Joint Commission on Accreditation of Hospitals . . . Directed that Resolution #13, which requests that MSNJ Delegates to the AMA petition that organization to investigate the method of survey and approval of the JCAH so as to enhance the emphasis on plant and equipment status of an institution, be referred to MSNJ's AMA Delegates.

Development of More Family Physicians . . . Directed that Resolution #14, calling for the establishment of Chairs of Family Practice in both colleges of the CMDNJ, and the expansion of facilities to enable each college to admit and to graduate at least 200 students a year, be referred to the Committee on Medical Education.

Peer Review Committee to Control Quality and Costs of Health Care . . . Directed that consideration of Resolution #16 be tabled until the July meeting of the Board, pending a report from Dr. James Rogers after the AMA meeting on peer review.

Reducing Duration of MD Curriculum . . . Directed that Resolution #19, which recommends that the medical college course be condensed to three years, be referred to the Committee on Medical Education.

Society Representation on Governmental Planning Councils and Agencies . . . Directed that Resolution #21, which calls for MSNJ seeking direct representation on all governmental planning councils and agencies, be received and agreed to place increased emphasis on seeking such representation.

Baccalaureate Program for Physicians' Associates . . . Directed that a letter go to the Deans of the two medical schools in New Jersey informing them of the action taken by the House of Delegates (Resolution #33) in disapproving the presently proposed baccalaureate program for physicians' associates.

MSNJ Participation in Certificate of Need Activities . . . Directed that Resolution #36, which calls for MSNJ to engage actively in a consultative capacity or to participate (by having formal representation) in the various committees of RMP who formulated guidelines on stroke, cardiovascular units, standards for coronary care units, and for coronary cineangiography units in community hospitals, be referred to the Council on Medical Services.

Liaison Committee with Fiscal Intermediaries . . . Directed that Resolution #39, which calls for the establishment of state and county committees to communicate with the fiscal intermediary on behalf of member physicians to insure that medical judgment is given adequate consideration, be referred to the Joint Medicare Claims Inquiry Committee.

Support of HMO Concept . . . Directed that a communication be sent to the sponsor of Resolution #43, which calls for the provision of ethical guidelines in the implementation of a Health Maintenance Organization, asking him to provide specific direction as to the types of ethical questions he feels are to be raised.

FDA Policy on Fixed Combination Drugs . . . Directed that Resolution #32, which urges the FDA to reconsider its action of categorically removing all fixed combination drugs from the market, and asks MSNJ Delegates to

the AMA to introduce a resolution to induce the AMA to take like action, be referred to MSNJ's AMA Delegates for implementation.

Minimum Eye Examination Rules . . . Directed that a letter go to the Secretary of the State Board of Medical Examiners requesting a hearing on the proposed Minimum Eye Examination Rules. (In accordance with action of the House on Resolution #34.)

Council on Smoking and Health . . . Directed that Resolution #35, which urges MSNJ to take leadership in reorganization of a New Jersey Interagency Council on Smoking and Health to implement effective programs to persuade young people not to start smoking and assist smokers to withdraw from the habit, be referred to the Council on Public Health.

Nomination to State Board of Medical Examiners . . . Directed that the following names be submitted to the Governor for consideration in filling a vacancy on the Board of Medical Examiners upon the expiration of the term of Carl N. Ware, M.D. (June 26, 1971):

Carl N. Ware, M.D., Millville
Nicholas A. Bertha, M.D., Wharton
Charles Cunningham, M.D., Vineland
Nicholas G. Demy, M.D., Somerville
William Greifinger, M.D., Belleville
Elbert H. Pogue, M.D., Elizabeth
Raymond A. Taylor, M.D., Toms River

Expansion of Executive Offices . . . Directed that the Society proceed with the expansion of the existing Executive Offices and that the Committee on House Maintenance, Staff Policies, and Personnel Relations, and the Executive Committee work together in making decisions of minor details. (Blueprint of proposed expansion was presented to Board for review.)

Annual Meeting Dates . . . Agreed to the following necessary changes in future Annual Meeting dates:

1972—May 6-May 9
1973—May 12-May 15
1974—May 11-May 14
1975—May 10-May 13

The FDA Efficacy Rule

The following item is an abstract of an article by Louis Lasagna, M.D., that appeared in the April 8, 1971, *Wall Street Journal*. Dr. Lasagna is Professor of Pharmacology at the University of Rochester.

Disturbing to many of us is the FDA decision summarily to remove drugs from the market without a hearing. For some years the Secretary of Health, Education, and Welfare has had the right to do this, if he makes a finding of "imminent hazard to the public health." Since 1969, the FDA commissioner has had such power regarding antibiotics. But no one could seriously label panalba an imminent health hazard, so that new phrases have been devised, such as "significant medical hazard" and "unwarranted hazard."

Why not grant evidentiary hearings? The FDA's capable chief attorney, W. W. Goodrich, explained why before the American Bar Association last August:

"Would it not have been better to proceed at least with a few hearings to elucidate the tests that should apply to the term 'substantial evidence?' The answer is that without these rules, the agency could not implement the NAS/NRC drug efficacy evaluations within the foreseeable future—not even within our lifetimes. A massive case load of the sort that FDA faces cannot be handled without procedural devices. The summary judgment rule is such a device."

(One wonders whether it will be suggested that some such approach might clear the crowded dockets of the courts of our land. Judges—district attorneys—could simply rule on the basis of the evidence as they saw it, without all that fuss and bother about adversary confrontation, cross-examination, a jury of peers, etc.)

One can sympathize with the FDA. In one sense its leaders are always stuck with the judgments of their predecessors (there have been four commissioners in five years) and thus may present an appearance of inconsistency or contradiction when they are simply

changing with the times. They are under attack from all quarters—at the moment, for instance, the drug industry is accusing them of hasty and cavalier actions, while the American Public Health Association and the National Association of Retired Employees has brought suit against the agency for being too slow to eliminate unwarranted drug claims. But we must not allow our sympathy as to the difficulty of the task to interfere with our objective judgment of the results.

An extremely worrisome specter is the impairment of the research and development programs of drug companies whose business would be substantially affected by the proposed FDA actions. The health of the public is crucially dependent upon efforts to search out and introduce new drugs and improvements of existing drugs. These efforts will be hurt by reduced revenues and earnings as financial restraints are exerted both upon the scale and riskiness of research and development projects that can be undertaken.

Safeguarding and promoting the public health is of utmost importance. That cause cannot be well served by an FDA policy which uses questionably valid procedures to condemn products that have the confidence of experienced practitioners, deliberately makes it difficult to consider relevant evidence, and undermines financial support for those processes of pharmaceutical invention, innovation, and improvement that are crucial to the long-run public good.

ATTENTION COMPONENT SOCIETIES

Please Note!

The 206th Annual Meeting of MSNJ will be held **May 6 to 9, 1972**. Please schedule your county meeting for election of delegates and alternate delegates so that the names can be forwarded to the Executive Offices no later than **April 1, 1972**.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the months of May and June:

	1971 May	1970 May
Aseptic Meningitis	5	10
Primary Encephalitis		1
Post Infectious Encephalitis	1	
Hepatitis: Total	307	272
Infectious	237	226
Serum	70	46
Malaria: Total	6	7
Military	5	6
Civilian	1	1
Meningococcal Meningitis	4	10
Mumps	246	314
German measles	126	151
Measles	381	255
Salmonella	64	54
Shigella	26	15

	1971 June	1970 June
Aseptic Meningitis	8	9
Primary Encephalitis	4	2
Hepatitis: Total	338	295
Infectious	255	224
Serum	83	71
Malaria: Total	13	6
Military	13	3
Civilian	0	3
Meningococcal Meningitis	4	3
Mumps	130	258
German measles	91	84
Measles	200	140
Salmonella	61	56
Shigella	18	30

New Gonorrhea Culture Screening Program

In recent years, gonorrhea has achieved epidemic proportions in New Jersey, as in the United States, and throughout the world. More cases of gonorrhea are reported each year than the next six most common reportable diseases combined.

A great difficulty in the control of this disease has been the inability accurately to diagnose infections in the asymptomatic female. Many women harbor the gonococcus not knowing they have been infected and without feeling sick. Until recently, control efforts were futile because laboratory procedures to detect gonorrhea in these un-

suspecting "carriers" were inadequate. The microscopic smear technics which had been used for many years, while accurate in the male, are only about 25 per cent reliable in the female. The culture method, on the other hand, permitted the growth of numerous other organisms present in the human host which tended to obscure the growth of gonococci in approximately 50 per cent of the cases.

Recently, however, a new culture medium was developed by two researchers from the Public Health Service, Dr. Thayer and Mr. Martin. This agar, the Thayer-Martin medium, provides an excellent nutrient for the *Neisseria gonorrhoeae* but retards the growth of other organisms. A growth medium is therefore now available accurately to detect infection in an estimated 98 per cent of asymptomatic females.

As a consequence of this discovery, the New Jersey State Department of Health has developed an innovative approach to the identification of gonorrhea among unsuspecting women throughout the State. With the very close cooperation of Neighborhood Health Centers, Family Planning Clinics, Gynecology Clinics, and a few private physicians, large numbers of women who receive pelvic examinations for other purposes are also being tested for gonorrhea.

To accomplish this, the State has purchased incubators which have been placed in strategic locations. Participating agencies collect cervical specimens, place them in a candle jar to create carbon dioxide atmosphere, and deliver them as soon as possible to the incubator. The following day, after 18 to 24 hours incubation, these specimens are delivered by courier to the State Laboratory in Trenton. Positives are reported by telephone to the submitting agency, usually within two days of submission.

All cooperating agencies are given the opportunity to notify their own patients of the test results. If no response is obtained within five days, a field representative is sent to the pa-

tient's home to encourage her to see her physician, return to the original agency if they provide treatment services, or go to the local health department clinic. Almost without exception those people contacted by field representatives have been grateful for the concern demonstrated by this Department for their health.

At the present time 23 agencies deliver specimens to ten separate incubator sites. Of the initial 5,844 specimens submitted, 384 (6.6 per cent) were positive for gonorrhea. We anticipate the collection of 50,000 specimens during the initial year. If 6.6 per cent are positive we will have prevented 3,300 unsuspecting women from developing possible serious pelvic problems. More important we will have reduced the reservoir of asymptomatic "carriers" of gonorrhea which should have a marked impact on the numbers of men who contract and spread this disease.

Rocky Mountain Spotted Fever

The spring and summer months, corresponding to periods of tick activity, are the seasons when Rocky Mountain Spotted fever (tickborne typhus) may be encountered. In this part of the country the dog tick (*Dermacentos variabilis*) is the vector responsible for transmission of the causative organism, *Rickettsia rickettsii*, to man. Children tend to be more commonly infected because of their closer contact with pets. A history or physical signs of tick bite is helpful in suggesting a diagnosis. However, evidence of preceding tick bite may be absent in up to 25 per cent of cases. Incubation period averages about 7 days with a range of 3 to 12 days. Non-specific manifestations including fever, chills, severe headache, and myalgias are encountered initially, and the characteristic rash does not usually appear until the third or fourth day of illness. The patient may show evidence of disseminated intravascular coagulation.

The New Jersey State Virology Laboratory performs a complement-fixation test for Rocky Mountain Spotted fever. However, neither complement fixing antibodies nor a

positive Weil-Felix reaction appear until the second week of illness. Acute and convalescent phase serum specimens on all suspected cases should be submitted to the State Virology Laboratory. If the diagnosis is suspected clinically, specific therapy should be begun promptly, without waiting for the results of laboratory studies. The tetracyclines and chloramphenicol are the antibiotics of choice, and the response to therapy is most effective when treatment is begun early in the course of the disease. The value of a high index of suspicion cannot be stressed enough in establishing the diagnosis.

Salmonellosis—1970

There were 759 New Jersey residents from whom salmonella isolates were made during 1970, an increase of 27 per cent over the previous 5-year average of 602. Twelve persons were found to harbor salmonellae at the time of death. Six of these infections were associated with chronic illnesses, but the remaining six people died as a direct result of an acute salmonella infection, usually gastroenteritis. A total of 3,267 patient days were accounted for by 296 persons hospitalized for a primary salmonella infection, for an average hospital stay of 11 days. These figures are conservative and do not include either additional in-patient days after completion of surveillance reports or additional days of hospitalization in persons acquiring infections in two nosocomial salmonella outbreaks.

Over 54 per cent of cases of salmonellosis occurred in children under 10 years of age and 20 per cent were under one year old. These findings are consistent with those of previous years and with the national pattern.

Fifty different serotypes were identified by the New Jersey State Bacteriology Laboratory in 1970, including five serotypes which had never been isolated before in New Jersey. As in previous years, *Salmonella typhimurium* was the most frequently isolated serotype, accounting for 19 per cent of the total isolates serotyped. Ten serotypes accounted for 75 per cent of the total. Most of these were among the ten most frequently isolated serotypes in previous years.

Survey of State Mental Health Resources

By contract with the New Jersey Senate, the American Psychiatric Association surveyed the mental health resources of our state during 1970. Significant findings include these. Rate of progress in our mental health needs and resources "does not compare favorably with that made in a number of other states." The survey praised the substantial and constructive planning in the 1963-1965 period but said that "much of the will for action then generated has been lost. Failure to achieve many of the goals resulted in increasing criticism of the State's Division of Mental Health and Hospitals and its Department of Institutions and Agencies." The national survey team concluded "that the governmental organization in New Jersey does not give the mental health program the visibility, identity, dignity, and support it needs. The director of the Division of Mental Health (analogous to the commissioner of mental health in other states) is found to lack authority over the institutions over which he must exercise command. Instead, power is in the hands of a non-professional board."

The Survey group recommended a separate state department of mental health with an M.D. as Commissioner, appointed by the Governor. They also urge regionalization of mental health services with a deputy commissioner for each of four or five regions, who would have jurisdiction over county as well as state psychiatric installations in the region. Also recommended was stronger collaboration with university facilities.

Note: Recent enactment of Chapter 136, 1971 Laws of New Jersey, transfers control of mental hospitals from the Department of Institutions and Agencies to the Department of Health and establishes a Health Care Administration Board within that Department.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Mario I. Veluz, M.D., 128 Beatty Circle, P.O. Box 144, Westville, Indiana 46391. Manila Central University 1949. Board eligible. Group, partnership, solo. Available.

Pankaj V. Master, M.D., 88 Fallbrook Bay, Niakwa Place, Winnipeg 6, Manitoba, Canada. B. J. Medical College (India) 1960. Board certified. Partnership, solo, or will organize department. Available May 1971.

A. Bhattacharyya, M.D., 15 West Erie Street, Albany, New York 12208. University of Calcutta (India) 1954. Board eligible. Group, partnership, salaried in hospital. Available January 1972.

DERMATOLOGY—Charles Wasilewski, M.D., 844 South Lincoln Avenue, Springfield, Illinois 62704. Jefferson 1963. Board certified. Group. Available July 1971.

FAMILY PRACTICE—Louis S. Zeiger, M.D., 415 Queen Anne Road, Cherry Hill, New Jersey 08034. University of Pennsylvania 1967. Group or partnership, but not solo. Available September 1971.

INTERNAL MEDICINE—Julius M. Jaffe, M.D., 964 Del Canado, San Rafael, California 94903. Leiden University 1963. Subspecialties, hematology and oncology. Board eligible. Association, hospital staff, or group (southern New Jersey). Available July 1971.

Barry A. Portnoy, M.D., 8008 Seawall Blvd., Galveston, Texas 77550. Emory 1966. Board eligible. Group. Available July 1972.

M. M. Rahman, M.D., 275 Bay 37 Street, Brooklyn, New York 11214. Dacca Medical (Pakistan) 1958. Board eligible. Group, partnership, or institution. Available July 1971.

Eugene F. Cheslock, M.D., 107 Beverwyck Drive, Gunderland, New York 12084. CMDNJ 1965. Subspecialty, hematology. Board eligible. Group. Available July 1972.

NEUROLOGY—Michael Weintraub, M.D., 31 Risley Road, Chestnut Hill, Massachusetts 02167. SUNY (Buffalo) 1966. Board eligible. Solo, partnership, or group. Available May 1971.

OBSTETRICS AND GYNECOLOGY—Myung H. Han, 1130 Stadium Avenue, Bronx, New York 10465. Woo-Suk University (Korea) 1962. Subspecialty, gynecologic endocrinology. Board eligible. Full time in a hospital group, or partnership. Available.

Teresita M. Gungon, M.D., 9316 Seaview Avenue, Brooklyn, New York 11236. Santo Tomas, 1961. Board eligible. Full-time hospital, group, or partnership. Available August 1971.

OPHTHALMOLOGY—Herman C. Jordan, M.D., 2 George Road, Winchester, Massachusetts 01890. Howard University 1964. Board eligible. Solo, associate, or group. Available July 1971.

Robert A. D'Iorio, M.D., 8 Whittier Pl., Apt. 22F, Boston 02114. Georgetown 1965. Board eligible. Partnership or group or solo. Available March 1972.

OTOLARYNGOLOGY—Melvin J. Gunsberg, M.D., Box 3, DeWitt Army Hospital, Fort Belvoir, Virginia 22060. NYU 1963. Board certified. Group, partnership, or solo. Available August 1971.

John B. Sekel, M.D., 4823 Flanders Avenue, Kensington, Maryland 20795. Georgetown 1966. Board eligible. Group, partnership, or solo. Available July 1971.

Alvin D. Oscar, 3319 Royal Oak Court. Columbus, Georgia 31907. Jefferson 1964. Board eligible. Partnership or associate. Available October 1971.

PEDIATRICS—Leon F. Kukla, M.D., 4730 North Post Road, Indianapolis, Indiana 46226. New Jersey College of Medicine 1966. Board eligible. Group, partnership, or institution. Available August 1971.

Richard G. Judelsohn, M.D., 2026A Tycoon Road, Atlanta, Georgia 30341. SUNY 1967. Board eligible. Associate or group. Available July 1972. (Buffalo)

U. K. Kim, M.D., 94 Hillcrest Drive, Victor, New York 14564. Ewha (Korea) 1957. Board eligible. Institutional, such as college health center, or public health field. Available September 1971.

PHYSICAL MEDICINE AND REHABILITATION—Pravin Panchal, M.D., 2441 Webb Avenue, Apt. 5A, Bronx, New York 10468. Gujarat University (India) 1965. Board eligible. Hospital. Available July 1971.

RADIOLOGY—Gamal-Eddin H. Hussein, M.D., 2411 Fifth Street, Fort Lee, New Jersey 07024. Ain-Shams University of Medicine 1957. Board eligible. Any position. Available.

M. A. Jafarzadeh, M.D., 314 West 56th Street, Apt. 4B, New York 10019. Tehran 1956. Board eligible. Partnership, group, or hospital. Available April 1972.

SURGERY—Choon Myong Park, 8700 Pennsburg Place, #4, Richmond, Virginia 23229. Seoul National University 1960. Board eligible. Group or partnership. Available July 1971.

Nemesio M. Elefante, M.D., 18724 Walkers Choice Road, Apt. 2, Gaithersburg, Maryland 20760. Santo Tomas (Philippines) 1959. Board eligible. Solo, group, or partnership. Available July 1971.

Abolfath B. Ardalan, M.D., 12300 McCracken Road, Cleveland, Ohio 44125. Tehran (Iran) 1962. Subspecialty, thoracic and vascular surgery. Board eligible. Group or partnership. Available July 1971.

Benjamin C. Agustin, M.D., 9316 Seaview Avenue, Brooklyn, New York 11236. Santo Tomas 1960. Board eligible. Full-time hospital, partnership, or group. Available August 1971.

David W. Fricke, M.D., 308 East Highland Avenue, Philadelphia, 19118. University of Pennsylvania 1960. Board eligible. Partnership or group. Available, August 1971.

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Medicare and Extended Care

Regulations issued in June 1971 are aimed at clearing up misunderstandings about the services that Medicare can pay for when an older person is in a nursing home or extended care facility. In providing for the payment of extended care following hospitalization, the Medicare program introduced a new concept by financing the cost of a new level of care, Commissioner Ball pointed out.

"This type of care covered," he said, "is not the general run of nursing home care, but the level of care generally required during the last part of a hospital stay when the patient no longer requires full hospital services, but still needs to be cared for in an institution in which skilled nursing care is available on a

continuous basis. The idea is to provide a less costly alternative to continued hospital care."

For Medicare to pay for this, the elderly person in a participating extended care facility must need and must be receiving services that meet the definition of "skilled nursing services," the kind of care that can be given only by skilled nurses.

Medicare cannot, for example, pay for a stay in a nursing home or extended care facility if the person is in the institution simply because he needs help in eating, dressing, getting around, taking medicine, bathing, or taking care of similar needs. Also, if skilled care is only needed on an occasional basis—for example, changing a special dressing once or twice a week—this in itself would not qualify the person for Medicare's extended care benefits. Skilled nursing services are those furnished by a licensed nurse and include the observation and assessment of the patient's needs, the planning and management of a treatment plan, and giving direct service to the patient.

The required frequency rather than the regularity of skilled nursing services determines whether they can be considered continuous. For example, a patient may receive intramuscular injections every second day, but if this is the only skilled service he needs, the fact that he is receiving regular injections would not call for the continuing availability of a skilled nurse. Observation of the patient's condition may be the principal continuous service when the unstabilized condition of the patient requires the skills of a licensed nurse to detect and evaluate the need for possible modification of treatment.

If an extended care facility is not sure whether Medicare can pay for a stay by a particular beneficiary, the institution may qualify to use a procedure for getting a quick decision from its Medicare intermediary by sending in a special request at the time of admission. More than half of the facilities certified to provide extended care under the Medicare program have qualified to use this procedure.

LETTERS TO THE JOURNAL

Smugness No Solution

12 May 1971

Dear Editor:

I thank you for printing my letter with what purports to be "an answer" by a Mr. Joseph A. Matt, writing for the Joseph A. Britton Agency. Manifestly, he wrote in support of the Britton Agency which I was not attacking. What I sought was consideration by the insurance company (over whose policies Mr. Britton could have no control) of a reduction of premium demands upon those doctors with many years' freedom from suits.

Mr. Matt reports that one out of every twenty doctors insured is sued each year, reasoning therefrom that every insured doctor will be sued every twenty years. If five per cent of the soldiers in our army contracted gonorrhea in any given year, would that doom all soldiers to acquire it if they remained in service twenty years? He states that premium surcharges are levied against any doctor having more than one suit in ten years but modifies that by stipulating that such surcharge is applied only to those adjudged to have deviated from accepted standards—but he avoids mentioning that since insurance coverage is not mandatory any doctor receiving such surcharge can dodge it by declining the policy. He states that a suit could cost the insurance company \$100,000 or more. Ask him how many doctors are insured, how many are sued, and what is the average yearly cost to the company?

Mr. Matt wants us to know that the insurance company is not considering the proposition I mentioned, but he has not made its present premium pattern seem equitable to me, or to others whose clean record as to claims for many years puts them in a preferential class, or should. Perhaps what his reply has accomplished is precisely what Mr. Matt

wouldn't have wanted, namely to convince me that The Medical Society of New Jersey should make a thorough inquiry as to what insurance coverage it can procure for its members at costs which will be in closer conformity to the risk they represent. A premium of \$628,000 (paid by me in 1970) is unfair for a doctor doing neither surgery nor radiography, and with a half century record of no suit. The risk suits from patients and the cost of liability insurance have much to do with the rising costs for doctors' services, and can discourage young men from entering medical schools. Smugness will not solve the problems confronting us today.

Albert G. Hulett, M.D.

Rejecting the Rejection

1 June 1971

Dear Mr. Editor:

What is the major stumbling block to organ transplants? The rejection phenomenon, of course. Some effort is made to neutralize this by repressing the body's immune reactions—but this, in turn, deprives us of defense measures.

It seems that a possibility for prevention of the rejection reaction exists. Both antigen and antibody are proteins. Their synthesis is based on the genetic code incorporated in the case of the antigen in the donor's DNA, and in the case of the antibody, in the recipient's DNA.

If it were possible to introduce donor DNA into the cells of the recipient, both the DNA of the donor and the DNA of the recipient would coexist in the same cell. Such coexistence of the two DNA's might preclude antibody formation and might evoke tolerance to the antigens of the donor introduced later by the transplant.

A cogent reason for the possibility of coexistence of the two different DNA's is offered by hybrid cells. In such cells, two DNA's, genetically much further apart than the two DNA's of homologous donor and recipient, coexist.

Alexander Strelinger, M.D.

ANNOUNCEMENTS

Clinical Application of Basic Sciences

For the third consecutive year, the Burlington County Memorial Hospital in Mount Holly will offer a series of presentations on the general topic, "Clinical Application of the Basic Sciences." Attendance is accepted for credit by the AAGP (1½ points per session). Lectures are supported by an educational grant from Merck, Sharp, and Dohme.

The September programs are as follows:

- September 9 Angina without Obstructive Coronary Disease
- September 16 Coronary Patients—from the Acute to Extended Care, to Convalescence
- September 23 Surgical Treatment of Coronary Artery Disease
- September 30 Surgery for Coronary Heart Disease

Meetings are held each Thursday at 3:30 p.m. in the Common Room of the T. J. Summey Building at the hospital. For registration and further information, please contact the Department of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Drug Abuse Seminar

Student drug abuse surveys will be the topic of an international conference in Newark, September 13, 14, and 15, 1971. This is sponsored by the Department of Public Health and Preventive Medicine, College of Medicine and Dentistry of New Jersey at Newark, and also by the Institute for the Study of Drug Addiction, New York.

"Drug abuse surveys are one of the main tools of drug abuse education," explained Stanley Einstein, Ph.D., Associated Director, Division of Drug Abuse, CMDNJN. Dr. Einstein is the Director of the Institute for the Study of Drug Addiction. "We felt that it was time really to study and discuss the concept of drug abuse surveys in depth, particu-

larly what meaning such surveys have in contemporary living," added Dr. Einstein.

The conference will explore survey methods and summarize reports of recent surveys. It will discuss confidentiality and the social implications. For more information, get in touch with the Division of Drug Abuse, New Jersey College of Medicine and Dentistry at Newark, 100 Bergen Street, Newark 07103.

Course On The Shoulder

A course—"The Shoulder—A Course in Depth"—is scheduled for September 18th and 25th at the College of Medicine and Dentistry of New Jersey at Newark. For more information, write to Anthony DePalma, M.D., College of Medicine and Dentistry of New Jersey at Newark, 100 Bergen Street, Newark 07103.

Trauma Seminar

On September 25, an all-day seminar on trauma, sponsored by the New Jersey Committee on Trauma of the American College of Surgeons (with cosponsorship by the College of Medicine and Dentistry of New Jersey and the Jersey City Medical Center), will be held at the Jersey City Medical Center. A panel of well-known speakers in the field of trauma has been selected. For further information, please contact Clifford R. Blasi, M.D., Chairman of the New Jersey Committee on Trauma, c/o Jersey City Medical Center, 50 Baldwin Avenue, Jersey City 07304.

Otolaryngology For The GP

On October 8 and 9, at Miami, the University of Miami School of Medicine will present a course in otolaryngology for the family physician. AAGP credit is 9 hours. For details, write to F. W. Pullen, M.D., Neuro-Otologic Laboratory, School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Florida 33152.

Medication for the Dying and the Bereaved

A symposium on "Psychopharmacologic Agents in the Care of the Terminally Ill and the Bereaved" is to be held in New York City on Friday, November 12, 1971, at the Columbia University Men's Faculty Club.

Manuscripts will not be read at the symposium, but will, rather, be mimeographed and distributed to participants in advance of the meeting date. For details (both for attending the symposium and offering papers) write to

I. K. Goldberg, M.D., Foundation for Thanatology, 630 West 168th Street, New York 10032.

Surgical Symposium in Hawaii

The Pan-Pacific Surgical Association is holding its twelfth seminar in Honolulu the last week in February and the first week in March, 1972. All surgical specialties will be covered. For details, write to Cesar DeJesus, M.D., 236 Alexander Young Building, Honolulu, Hawaii 96813.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1971

September

- 9 Burlington County Memorial Hospital
Mount Holly
Angina Without Obstructive Coronary Disease

- 13-17 Academy of Medicine of New Jersey
University of Rome and University of Belgrade
Postgraduate Medical Symposium

- 16 Burlington County Memorial Hospital
Mount Holly
Management of Coronary Patients from the Acute to Extended Care of Convalescence

- 23 Burlington County Memorial Hospital
Mount Holly
The Evaluation of Patients for Surgical Treatment of Coronary Artery Disease

- 30 Burlington County Memorial Hospital
Mount Holly
Experience in Surgery for Coronary Heart Disease

October

- 6 American Academy of General Practice, the Academy of Medicine of New Jersey, and Middlesex General Hospital

Middlesex General Hospital, New Brunswick
Recent Advances in Internal Medicine and Therapeutics

- 7 Burlington County Memorial Hospital
Mount Holly
The Doctor-Patient Relationship

- 14 Burlington County Memorial Hospital
Mount Holly
Masked Depression in Medical Practice

- 21 Burlington County Memorial Hospital
Mount Holly
The Influence of Language upon Symptomatology in Foreign-born Patients

- 25-29 Saint Barnabas Medical Center
Livingston
Obstetric and Gynecologic Pathology

- 27 Academy of Medicine of New Jersey
Saint Michael's Medical Center, Newark
Hospital acquired infections

- 28 Burlington County Memorial Hospital
Mount Holly
Unusual Post Surgical Pain

November

- 4 **Burlington County Memorial Hospital**
Mount Holly
Cranio-Cerebral Trauma
- 10 **New Jersey Dental Association**
Semi-Annual Session
- 10 **Academy of Medicine of New Jersey**
Saint Michael's Medical Center,
Newark
Chronic Renal Disease and Dialysis
- 10 **Academy of Medicine of New Jersey**
Hoffman-La Roche, Nutley
Alcoholism
- 11 **Burlington County Memorial Hospital**
Mount Holly
Crushing Injuries of the Chest
- 17 **Academy of Medicine of New Jersey**
Saint Michael's Medical Center,
Newark
Pharmacology of Diuretics, Indications and Use
- 18 **Burlington County Memorial Hospital**
Mount Holly
Peritoneal Dialysis in the Community Hospital

December

- 2-3 **Saint Barnabas Medical Center**
Livingston
Gynecological Endoscopy
- 2 **Burlington County Memorial Hospital**
Interservice Seminar
- 8 **Academy of Medicine of New Jersey**
Saint Michael's Medical Center,
Newark
Urological Workshop including Prostatic Diseases
- 9 **Burlington County Memorial Hospital**
Mount Holly
The Management of Suspected Testicular Neoplasm
- 16 **Burlington County Memorial Hospital**
Mount Holly
Medical and Surgical Management of Urolithiasis

- 30 **Burlington County Memorial Hospital**
Mount Holly
Evaluation and Management of the Arthritic Hip

1972

January

- 6 **Burlington County Memorial Hospital**
Mount Holly
Viral Hepatitis: A Reappraisal of Mild Hypertension
 - 11 **Academy of Medicine of New Jersey**
Bloomfield
Sectional Meeting: Dermatology
 - 13 **Burlington County Memorial Hospital**
Mount Holly
Current Concepts of Cardiomyopathy
 - 19 **Academy of Medicine of New Jersey**
College of Medicine and Dentistry at Newark
Advances in Radiotherapy
 - 20 **Burlington County Memorial Hospital**
Mount Holly
Current Trends in the Therapy of Mild Hypertension
 - 27 **Burlington County Memorial Hospital**
Mount Holly
Orthostatic Hypotension
- ### February
- 3 **Burlington County Memorial Hospital**
Mount Holly
Problems Related to Antidiuretic Hormones
 - 10 **Burlington County Memorial Hospital**
Mount Holly
Neurological Complications of Visceral Carcinoma
 - 17 **Burlington County Memorial Hospital**
Mount Holly
Full Time and Voluntary Staff—The Interface
 - 24 **Burlington County Memorial Hospital**
Mount Holly
Newer Approaches to Community Health

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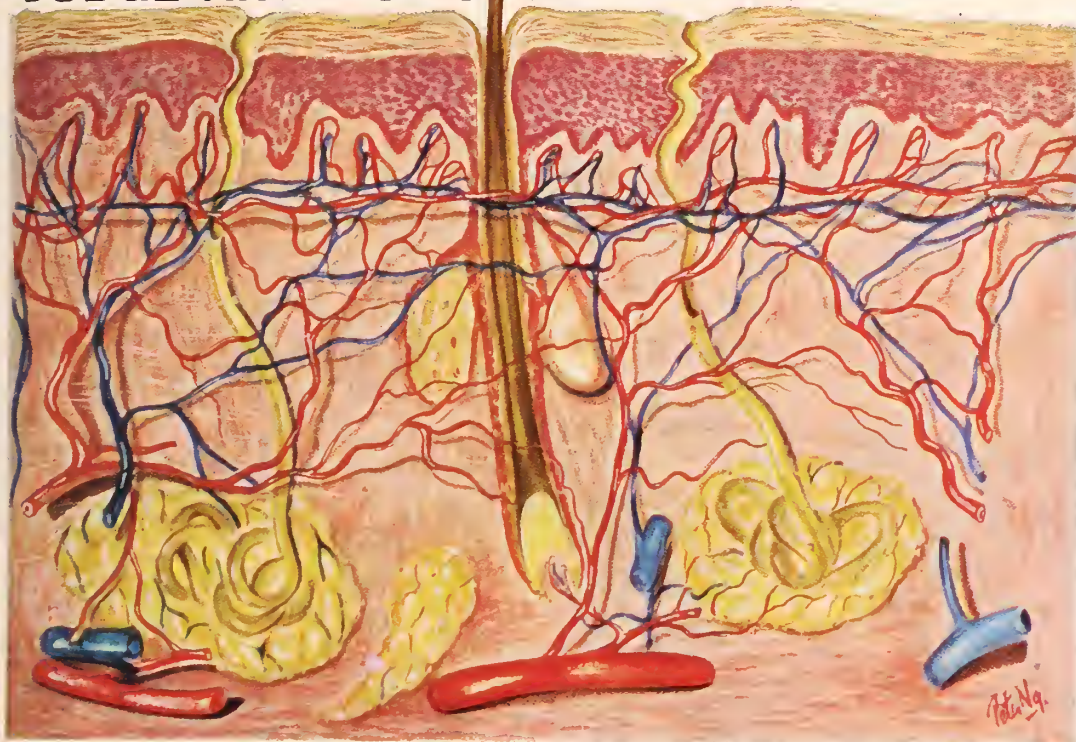
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OBITUARIES

Dr. Edward Alpert

Senior citizens and physicians of Hudson County will remember Edward Alpert, M.D., of Jersey City, who retired from practice in 1966. He was a Fordham University medical graduate, class of 1921. He was affiliated with the staff of the Jersey City Medical Center, and was proud to be called a family doctor. Born in 1899, he died in retirement in Hollywood, Florida, on April 1, 1971.

Dr. Frank Altschul

A colorful medical career came to an end on May 13, 1971 with the death on that day of Frank J. Altschul, M.D., at the age of 72. Born in Honduras at the turn of the century, he came to the USA to enter the College of Physicians and Surgeons at the end of World War I. His M.D. degree there was granted in 1921. After interning, he essayed a brief period of private practice in New York, but in 1924 he came to Monmouth County in New Jersey. He has, since then, served the people of the shore area. He was an internist affiliated with the staffs of Riverview Hospital in Red Bank and the Monmouth Memorial in Long Branch. He was a practitioner with an early interest in geriatrics.

Dr. Mary Bacon

In 1967, the Women's Medical Association named her "Medical Woman of the Year." In 1944, she was elected president of our Cumberland County Medical Society. In 1969, she was the laureate of the Academy of Medicine's Edward J. III Award. This was Mary Bacon, M.D., of Bridgeton, New Jersey. Born in 1893, she died on May 21, 1971 at the age of 78. Her M.D. degree came from Women's Medical College in 1916. For a decade, she was a member of the Bridgeton Board of Health. From 1947 to 1960 she was

Secretary of the Cumberland County component. For more than half a century she served the people of southern New Jersey as a pediatrician, obstetrician, and most of all, as a family doctor. She was affiliated with the staff of the Bridgeton Hospital during her professional career in our state.

Dr. Johannes F. Bielski

At the grand age of 82, Johannes Bielski, M.D., died on June 18, 1971. Born in Germany in 1889, he was graduated in 1919 from Albert Ludwigs University in Freiburg, Germany. He came to the USA at the end of World War II, obtained a New Jersey medical license, but practiced as a full-time house physician for the Middlesex General Hospital until his retirement in 1956. He then lived in Forest Hills, New York. Dr. Bielski had been a member of our Middlesex County Medical Society.

Dr. Arthur R. Borchek

At the untimely age of 56, Arthur R. Borchek, M.D., died on April 4, 1971. He was a general surgeon who had earned his M.D. degree at the Long Island College of Medicine in 1941. He was on the staff of the Christ Hospital in Jersey City and was a member of our Hudson County Component Society.

Dr. Harry R. Brindle

One of Monmouth County's leading roentgenologists, Harry R. Brindle, M.D., died on June 10, 1971. He is remembered as Director of the Radiology Service and Chief of Staff at Fitkin Memorial (now Jersey Shore) Hospital. Born in 1908, he received his M.D. at Jefferson with the class of 1935. He became board certified in his specialty and was a Fellow of the American College of Radiology. Dr. Brindle was President of our Monmouth County Medical Society in 1947-1948.

Dr. J. Paul Burkett

One of southern New Jersey's leading internists, J. Paul Burkett, M.D., died on May 2, 1971 at the age of 63. During World War II, he was a medical officer in the U.S. Navy with extensive combat service. Dr. Burkett was in the class of 1934 at Hahnemann, and was on the staff of the Underwood Memorial Hospital in Woodbury. He practiced in that city and was active in the affairs of our Gloucester County component.

Dr. Edmund J. Daly

Born in 1887, during the first administration of Grover Cleveland, Edmund Daly received his medical degree at Dartmouth in 1912. He was, for several decades, active in the affairs of the Hudson County Medical Society and was on the staffs of the St. Francis Hospital and the Medical Center in Jersey City. Dr. Daly was a pioneer urologist, an early diplomate of the American Board of Urology. He was a laureate of our Golden Merit award in 1962. Dr. Daly was 84 years old at the time of his death on April 4, 1971.

Dr. Ferdinand Fader

Born in 1910, Ferdinand Fader, M.D., died at the age of 61 on April 20, 1971. He was a 1935 graduate of the medical school at the University of Maryland. During World War II he was a captain in the U.S. Air Forces (then called the Army Air Corps). He was a family doctor who practiced in East Orange and was affiliated with the East Orange General Hospital. He was active in committee work for our Essex County Medical Society.

Dr. Julius Gerendasy

Generally considered one of Union County's pioneers in gastroenterology, and proctology, Julius Gerendasy, M.D., died on May 27, 1971, at the age of 79. He was a prolific writer in his chosen specialty, and was on the staffs of most of the hospitals in the Union County area. Dr. Gerendasy earned his medical degree at Bellevue in 1916.

Dr. Max Horn

A member of Yale Medical School's class of 1925, Max Horn, M.D., practiced in New Jersey for 40 years. He died on May 12 at the age of 72. He began his medical career in pathology, and in his long subsequent career as a surgeon always insisted that a grasp of tissue pathology was the essential foundation for a successful practice of clinical surgery. He served the Newark Board of Education for two decades, was a Fellow of the American College of Surgeons, and was affiliated with the surgical staffs of most of the hospitals in the Newark area. He enlisted in the U.S. Army at the age of 18, working as a corpsman in the medical department. During the 1930's, he was active in our Essex County Medical Society.

Dr. Grover H. Jensen

Grover H. Jensen, M.D., was a general practitioner in Jersey City for some years and then moved to Cedar Grove. During the Hudson County part of his career, he was on the staffs of both the Fairmount and St. Francis Hospitals in Jersey City, and, on moving to Essex County became affiliated with both Mountainside and St. Vincent's Hospitals in Montclair. He earned his M.D. at Temple in 1924 and was one of the early members of the American Geriatric Society. Dr. Jensen was a life-long member of the Academy of Medicine. Born in 1897, he died on May 1, 1971 at the age of 74.

Dr. George L. Kingslow

A well-known Hackensack general practitioner, George L. Kingslow, M.D., died on May 1, 1971, at the age of 73. He was a Bellevue graduate, class of 1926. He organized the venereal disease clinic at the Hackensack Hospital where he was also an attending in medicine.

Dr. K. Virginia Maurer-Alden

Word has come from Havertown, Pennsylvania, of the death there on May 2, 1971, of K. Virginia Maurer-Alden, M.D. Born in 1906,

she was 65 years old at the time of her death. She was a 1931 alumna of the Medical School at Temple University—a family doctor who, for many years, served the people of Essex County. She was a school physician, and was affiliated with the East Orange General Hospital. Dr. Maurer-Alden was active in the affairs of the American Medical Women's Association.

Dr. Dominic C. Macaluso

A 1932 graduate of the Medical School at Washington University in Saint Louis, Dominic Macaluso, M.D., was a member of our Essex County Medical Society. Born in 1909, he was a family doctor, practicing in Belleville. Dr. Macaluso, who was on the staff of the Clara Maass Hospital, died on May 2.

Dr. Paul J. Pegau

Born in 1899, Paul J. Pegau, M.D., was a 1925 alumnus of the Jefferson Medical College. He was a member of the Woodbury, New Jersey, Board of Health and a pioneer in the development of the Emergency Department of the Underwood Memorial Hospital in Woodbury. He was a pediatrician with special interest in allergies in children. Dr. Pegau died on April 7, 1971.

Dr. Anthony Pino

A senior attending surgeon at the Bridgeton Hospital, Anthony Pino, M.D. was a 1931 graduate of Hahnemann. He served the people of Cumberland County from 1932 until he died on May 10, 1971 at the age of 66. He was active in the affairs of our Cumberland County Medical Society.

Dr. David Schein

On May 23, 1971, David Schein, M.D., of Linden, New Jersey, died at the age of 64. He was a general surgeon on the staff of both the Alexian Brothers Hospital and St. Elizabeth's Hospital. He was a 1933 graduate of the Long Island College of Medicine and a Fellow of the International College of Surgeons.

Dr. Armand G. Sprecher

Armand G. Sprecher, M.D., spent most of his professional career in the Philadelphia area. A member of the Philadelphia County Medical Society, he came to Ocean City in our state in 1969 and transferred his membership to the Cape May County Medical Society. Born in 1902, he was 69 years old at the time of his death on April 22, 1971. Dr. Sprecher was an early clinician in the field of rheumatology and was affiliated in that specialty at the Shore Memorial Hospital in Somers Point. He received his M.D. at the University of Pennsylvania in 1926.

Dr. Fred Vosburgh

A past president of the Passaic County Medical Society, Fred Vosburgh, M.D., died on April 16, 1971 at the age of 78. He was an Albany Medical College graduate, class of 1915. Dr. Vosburgh was a family doctor of the old school and served the people of Passaic and Clifton from 1916 until his death.

Dr. William Wiren

Attending in family practice at the Bayonne Hospital and Dispensary, William Wiren, M.D., died on April 10, 1971. He was a 1921 alumnus of Bellevue, and was a member of our Hudson County Medical Society. Dr. Wiren was active in the fields of gerontology and geriatrics, and was a Fellow of the American Geriatric Society. He was 71 at the time of his death.

Dr. Robert Yaeger

At the untimely age of 43, Robert M. Yaeger, M.D., died on March 3, 1971. A New York Medical College graduate (class of 1956), Dr. Yaeger was active in geriatric medicine, and had been affiliated with both the Hamilton and the St. Francis Hospitals in Trenton. Dr. Yaeger also contributed to the programs of the American Academy of General Practice.

REVIEWS BOOK

Early Orthopaedic Surgeons of America. Alfred R. Shands, Jr., M.D. St. Louis, 1970, Mosby. Pp. 190. Illustrated. (\$15)

Shands has contributed to our orthopedic heritage by assembling under one cover biographies of eleven early orthopedic giants of this country. He reviews the lives of William Ludwig Detmold, Louis Bauer, Lewis Albert Sayre, Henry Gassett David, James Knight, Virgil Pendleton Gibney, Charles Fayette Taylor, Newton Melman Shaffer, John Ball Brown, Edward Hickling Bradford, and DeForest Willard. The final chapter is devoted to a brief summary of each biography. These men helped to establish the practice of orthopedics in this country as a specialty and founded institutions which still stand in tribute to their vision and courage.

Biographers are not always capable of bringing the subject to life for their readers. Shands has succeeded in accumulating the important factual data about these men. Today's orthopedists will find accounts about the early controversies regarding the value of bracing, the etiology of Pott's disease, and the value of tenotomies in the treatment of contractures—all concepts we now tend to take for granted—intriguing reading. With the Lord's help, future generations of orthopedists will read about our current notions of the etiology of scoliosis, reconstruction of arthritic joints and treatment of bone tumors, for example, with similar knowing amusement. The book is well illustrated.

PETER N. CARBONARA, M.D.

Control Processes in Multicellular Organisms. (Ciba Foundation) Edited by G. E. W. Wolstenholme and Julie Knight. Baltimore, Maryland, 1970, Williams and Wilkins. Pp. 424. Illustrated. (Price not stated)

The volume is a record of a symposium on Control Processes in Multicellular Organisms held by the Ciba Foundation in New Delhi, India in 1969.

Papers covered include *in vitro* studies of the lacoperon regulatory system, modulation of enzyme activities by metabolites; the rule of cyclic AMP in certain biologic control systems; insulin and growth hormone control of protein biosynthesis; hormonal control of metamorphosis; feedback control of ACTH secretion, with particular reference to the role of transcortin in pituitary-thyroid-adrenocortical interactions; interaction between thymus cells and bone marrow cells in response to antigenic stimulation; regulation of visceral activities by the central nervous system; some general integrative aspects of brain function; and many others.

Biologists, biochemists, cellular microbiologists, and physiologists will find nutritive material in the publication.

This reviewer cannot accept Livingston's definition of patriotism as "a cultural force to oblige conformity of perceptual and judgmental experiences, and it is dangerous and counter-constructive, for a society that

seeks to orient itself to reality." Such subversive dogma has no place in a lecture on "Integrative Aspects of Brain Function."

My definition of patriotism: A cultural force which confers upon the ego a mantle of individual pride in its environment, enabling it to withstand hardship and associate with others in a satisfactory work program; which teaches self-sacrifice; and which sustains one so that, at times, acts of superhuman strength may be accomplished in an environment wherein the organism knows it may be destroyed.

Thomas K. Rathmell, M.D.

Behavioral Sciences and Mental Health. U. S. Public Health Service Publication No. 2064. Washington, D.C., 1971. Pp. 419. Paperback (\$2)

The National Institute of Mental Health has been a prime mover in stimulating and supporting mental health and behavior studies in the four corners of the nation. The present volume is a compilation of 25 of their "Program Reports." The included reports cover material on how the brain works, how we learn, how behavior develops and what personal and cultural factors shape human behavior. The investigations touch on an astonishing variety of forces—music, anthropological factors, political commitments, education, biological rhythms, genetics, visual media, and so on. This should be a valuable source book for many decades to come, and the arrangement of the separate sections will permit the curious reader to dip into it at will, always sure of finding something interesting.

William Schram, M.D.

A Synopsis of Pharmacology. Edition 2. V. C. Sutherland, Ph.D. Philadelphia, 1970, Saunders. Pp. 720. Illustrated. (\$10.75)

Time was when medicines were the proper study of Medicine. Indeed, physicians who were graduated before World War I, had to learn the botany of the available drugs and the medical students then had to know a good deal about pharmacognosy. Today's students can scarcely pronounce or even define that word. The enormous growth of the pharmaceutical industry, the prepackaging of medicines, the compact literature furnished by the drug companies, and the development of non-pharmacologic therapies, all have loosened the medical practitioner's interest in understanding the chemistry and pharmacology of medications. It seems wasteful to learn these minutiae when your friendly detail man will tell you all about them.

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NOTE: Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible. Should not be given to patients who have received an MAOI within two weeks.

Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. **Anticholinergic:** Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. **Dther:** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. **Withdrawal Symptoms:** Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

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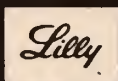
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EDITORIALS

The Practitioner's Experience with Medication

The old "town and gown" controversy has been an issue for centuries. Among attorneys, for instance, there is argument between the views of the academic law teachers, the professors, and the deep thinkers in the realm of the higher jurisprudence, contrasted with the needs, problems, and suggestions of the practicing lawyer. In academic legal circles, the phrase "mere practitioner" has some pejorative implications. School-centered legal teaching is a relatively recent product (since, perhaps the 1920's). Earlier, most barristers learned the profession by clerkships or apprenticeships. In our own profession, this method of learning and teaching medicine did not really have much of a foothold after the middle of the 19th century. But by the beginning of our century, it became pretty well accepted that you had to go to medical school to become a physician.

Elements of the controversy still exist. Latest sample is the present dispute about FDA rulings on the effectiveness of certain drugs and drug combinations. At one time, the complaint was that federal bureaucrats were making decisions about medical practice. Now, the agency summons M.D. experts of unquestioned intellectual attainments and *they* make the recommendations. Largest pool of this distinguished medical manpower is found in medical school faculties. Net result is that practicing physicians are almost excluded from the decision-making process. Of course, the professors and their associates (who, apparently, do have the decision-making authority) are also involved in the day-by-day care of patients. But since so much patient care is in the hands of clinicians outside the schools, it would seem as if their voice should be heard too. Any true spectrum of medical opinion should certainly include the actual day-by-day experience of the physicians on

the firing line. Their consensus, over the years, must surely be given some weight.

There is another angle to this that is seldom thought of by the FDA or the colleges. Suppose the working doctor, the "mere practitioner" (as it were) prescribes the medication and then the patient says he had an adverse reaction and starts malpractice litigation. Who, do you think, is going to be sued? The college? The FDA? No. It is the practitioner, the one man who did not participate in the decision-making process, who is going to be held accountable.

Peer Review Not a Panacea

Organized medicine is generally in favor of peer review. It is hard to see how surgical skills in the operating room can be evaluated except by another surgeon, and no one wants a colleague breathing down his neck at the operating table. Most of us are uncomfortable at having someone evaluate our performance. One thinks of principals and department heads entering a classroom and watching the teacher teach. Peer review is not the favorite occupation of any of us, whether we are being reviewed or whether we are passing judgment on a colleague.

But we can hardly oppose it, since the alternative is to invite review by those who are not our peers. Anyway, it is probable that a sense of accountability to our brethren will do us all good. But let it be remembered that it is not a panacea. Much of medicine is involved in interpersonal relations, rapport, and charisma—in what is conventionally called the "art" as distinct from the "science" of our work. That's no more measurable than the beauty in a painting or a symphony. Much peer review, anyway, has to be *post facto*. So while it is a healthy movement, and we can welcome it, let us not oversell it as the answer to every patient's prayer. It really can't be *that* effective.

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The Unwanted Child & Birth Control

Ten thousand battered children—a growing medical problem?

In his daily practice the physician witnesses the human suffering caused by uncontrolled fertility. Perhaps one of its most tragic effects is the unwanted child, who so often experiences parental rejection. The rejected child in a family may be neglected, nagged and severely punished. Sometimes he is criminally abused. Child abuse is common enough to have become a separate clinical entity: the "battered child" syndrome. Reliable statistics are difficult to obtain, but it has been estimated that in this country alone roughly 10,000 children are "battered" per year, and their number may be increasing.

A revealing picture of child abuse patterns is

provided by one study of the American Humane Society. More than half of the 662 children involved (all reported in newspapers within a single year) were less than 4 years of age. One fourth of the battered youngsters died; most of these deaths were of children less than 2 years of age. Fathers were more often guilty of child abuse than mothers, but sometimes both parents participated. The study indicated that battered children are not limited to any particular socioeconomic stratum.

***For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative.** Explored in the forthcoming issues will be the history of birth control, the influence of poverty, ethnic factors and marital status, its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain^{1,2} leading to this conclusion, and one³ in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll¹ was about sevenfold, while Sartwell and associates² in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of

them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function; increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X, thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test and pregnanediol determination.

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ORIGINAL ARTICLES

No need to get uptight yet about the nevus, suggests Dr. Brodtkin.

Malignant Melanoma*

The Antecedent Lesion—Junction Nevus?

Roger H. Brodtkin, M.D./Irvington

Does malignant melanoma begin in a benign junction nevus or is it malignant from the start? We can find support for either contention in the literature.^{1, 2, 3} The controversy centers about two points. First, was the "mole" which preceded the melanoma benign since it has been present for so long and appeared previously so innocent? Second, can the pathologists distinguish, from their morphology, whether the different cells in a melanoma or mole are actually benign or malignant?

Whatever the answer, malignant melanoma is a dreaded cancer. This fear along with the uncertainty of the relationship between the benign junction nevus and malignant melanoma has bestowed an unsavory reputation upon the benign junction nevus. There has developed a pervasive feeling of danger about these lesions. This fear must be recognized as a feeling, not established on good scientific evidence. Otherwise, the search for the truth will cease and the concept of "prophylactic removal" of nevi may extend to increase our work, our medico-legal obligations, and cause unnecessary trauma to certain patients.

Review of our knowledge of the evolution of the nevus cell is important here and may point up the need for investigation into this relationship.

The nevus cells which compose this tumor are apparently related to melanocytes. Melanocytes are present in the skin of the newborn human but nevi are rarely observed there. After several years of life, nevi begin to appear and gradually increase in number. They become most numerous on the torso but may be found anywhere on the skin and mucous membranes. Although they are not apparent at birth, the locations of nevi are determined in the first months of life, as is illustrated³ by the split nevus of the eyelid. These nevi of childhood are histologically of the "junction type" and statistically we know that they are benign. It might be presumed that some stimulus becomes active at around four or five years of age to cause proliferation of the nevus cells at the dermo-epidermal interface, allowing the clinical appearance of junction nevi at this time. Whatever this stimulus is, it apparently results in a benign proliferation, since malignant melanoma is so rare at this age. Interestingly, when melanoma does occur in this younger age group, it often develops in the bathing trunk type of nevus which is present at birth, unlike the common type of nevus, and perhaps is not governed by the same stimulus. It is also suggested that the stimulus or the target nevus cells in the ordinary junction nevus may be under some genetic control regarding the

*Read before the Sections on Dermatology and Pathology, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1971.

number, size, type, and location of nevi. At any rate, as the child grows, his nevi begin to change. Grossly, many of them begin to become elevated. This coincides roughly with the attainment of the individual's greatest number of nevi. At this time, histologically one may see nests of nevus cells in the dermis. These dermal nevus cells are presumed to have originated from junctional nevus cells. By the process of multiplication and *abtropfung*, the compound nevus becomes established as the common type of nevus in young adulthood. It must be presumed that some stimulus has been active during these years to convert junction nevi to compound nevi, a benign multiplication and relocation of nevus cells. Malignant melanoma is relatively uncommon at this age.

The life of the ideal nevus continues to its final stage of maturation by, presumably, becoming entirely intradermal and then disappearing by connective tissue replacement. Clinically, just as we have observed the appearance of flat nevi and their becoming elevated, also, by counting nevi at various ages, we can determine that in older individuals, there are fewer nevi. It has been said⁴ that if we could all live to be over 90, we would probably depart from life as we enter it, free of moles. Whatever stimulus is present to cause the disappearance of these nevi seems to correspond to the time of life when malignant melanoma is most common. Apparently the melanoma cell is not influenced by or is not influenced in the same way that the nevus cell is by this stimulus.

It must be understood that this account of the life and maturation of the nevus is artificial and not always such a consistent, orderly progression. It has been demonstrated⁵ by serially sectioning intradermal nevi that some junction theques may be found in 80 per cent of them. There are two important implications in this study: (1) clear classification of nevi into junctional, compound, and intradermal is too artificial and arbitrarily imposes sharp divisions on what appears to be a gradual, dynamic progression; (2) the concept of *junction nevus* has little significance from the

point of view of malignant potential because most intradermal nevi (and in fact, most nevi) have junctional elements. It may be that most junctional nevi have intradermal elements since we do not routinely serially section all nevi. Our classification of the routine nevus passing through the laboratory is therefore usually based on limited information. These names—junction, compound, and intradermal are conveniences of diagnostic classification. No implications of benign or malignant potential should be drawn from these labels.

The maturation of nevi, this dynamic process, tends to proceed at a different rate in different areas of the skin. Maturation occurs earlier and is more complete on the head than on the torso and progressively less on the lower extremities, upper extremities, genitalia and buttocks, and lastly the palms and soles, where nevi tend to remain fixed⁶ in the "junction" stage. Because of the tendency of nevi of the palms and soles and genitalia to remain junctional, suspicion of malignant potential has developed about these lesions. Justification for this suspicion by clinicians seems to be that melanomas develop from junction nevi; nevi of the palms, soles, and genitalia remain junctional throughout a large part of the life of the individual and therefore expose him to a prolonged possibility of malignant development in nevi found here. One might reason from our discussion, equally speciously, that if these nevi are fixed in a relatively immature state and melanoma is statistically rare during the time when most nevi are immature, they should not become melanomas.

Other than this sort of speculation, the facts have been pretty much established in this sort of case. Actual counts of the nevi of palms and soles show that they are present in 9 per cent of individuals on the palms and 6 per cent on the soles and none in the nail beds.⁶ Junction nevi of this same sort do not persist on the face but are the first and most frequent to become compound or intradermal. Compare this with the topographic distribution of malignant melanoma in which

the incidence of melanoma has been calculated based on the relative surface area of the anatomic region. This gives us a more accurate picture of the predilection of malignant melanoma for a specific anatomic site. The soles, the head, and neck are the anatomic areas of the greatest predilection. The subungual areas and the female genitalia show a similar high predilection. The penis, scrotum, and palms of the hands, however, exhibit the least predilection² for malignant melanoma. These figures do not provide compelling evidence then that nevi which tend to remain junctional represent an increased hazard of melanomatous conversion.

Examine the literature on whether, in a large series of malignant melanomas, the melanoma was preceded by a benign junction nevus. Ask what proportion of malignant melanomas contain benign nevus. You may find statistics of such variance and diagnostic criteria so inadequate and arbitrary that any conclusions drawn from this approach are worthless. One cannot help but recall the unjustified aspects of the concern over keratoacanthoma, juvenile melanoma, solar keratosis with Bowenoid changes, and psuedo sarcomatous fasciitis.

I hope that several points have been made

from this: (1) We tend to be suspicious that junction nevi may have malignant potential; (2) Our current knowledge of the evolution of the nevus cell nevus does not suggest that it is potentially malignant; (3) Our suspicions of malignant potential for the junction nevus are based upon rather weak and often controversial evidence. We simply do not know how or where the malignant melanoma arises or if they can arise from a junction nevus. The fact does remain, however, that the clinician cannot be certain that a "mole" is *not* a melanoma without removing it and subjecting it to microscopic examination. I feel like having run the bases, I return to where I started. If a point has been made, it is that we do not know the answer to this problem and must continue to search for it.

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40 Union Avenue

Health Care for Adolescents

"Too old" for the pediatrician, but "too young" to seek their own doctor, adolescents have often been neglected by medical personnel. A review of the complex physiologic and psychologic changes in teenagers which affect their well-being, as well as typical and special adolescent health problems, is contained in *Health Care for the Adolescent*, by June V. Schwartz, M.D. This new Public Affairs Pamphlet (No. 463) is available for 25 cents from the Public Affairs Committee, 381 Park Avenue, South, New York 10016.

In adolescent units, which are gradually being established in medical centers throughout the country, the goal is total care, "which may include vocational guidance, counseling, and rehabilitation under the supervision of a primary physician." Although there are not yet enough of them to meet the needs of millions of young people, these units do provide doctors with training in the special needs of the adolescent. Dr. Schwartz sees these developments as eventually making for healthier adults.

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Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.^{1,2}

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electroencephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

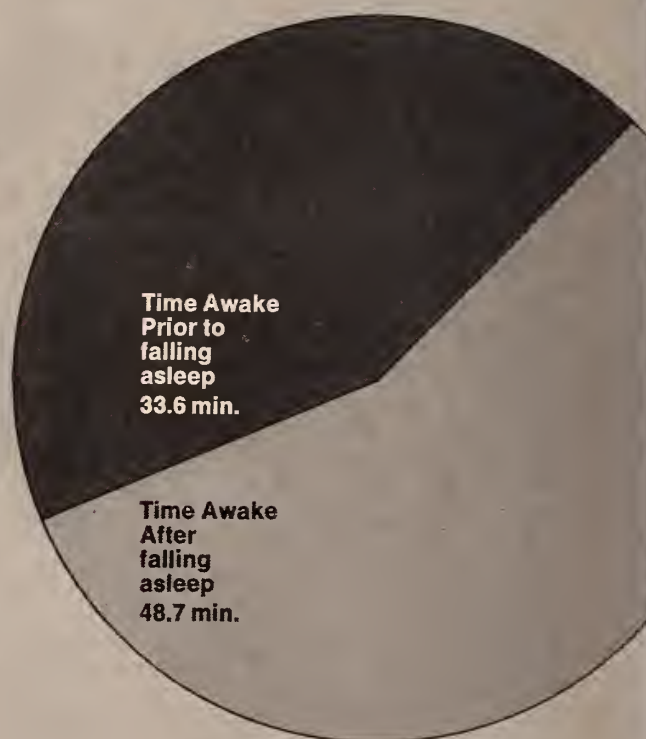
Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

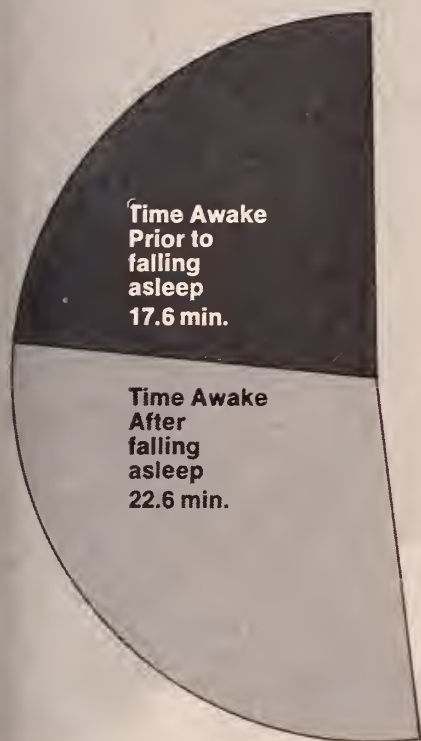
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

Before
Dalmane
(flurazepam HCl)



and slept through the night

On
Dalmane
(flurazepam HCl)



Average sleep laboratory measurements in cited studies

Parameter	Before Dalmane	On Dalmane
Time required to fall asleep	33.6 min.	17.6 min.
Wake time after onset of sleep	48.7 min.	22.6 min.
Number of wakeful periods after onset of sleep	12.2	8.4
Total sleep time	420.0 min.	447.5 min.
Total sleep percent	88.6	94.5

Clinical effectiveness as
proven in the sleep laboratory

Dalmane®

(flurazepam HCl)

30-mg capsule h.s.—usual adult dosage.
15-mg capsule h.s.—initial dosage for
elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

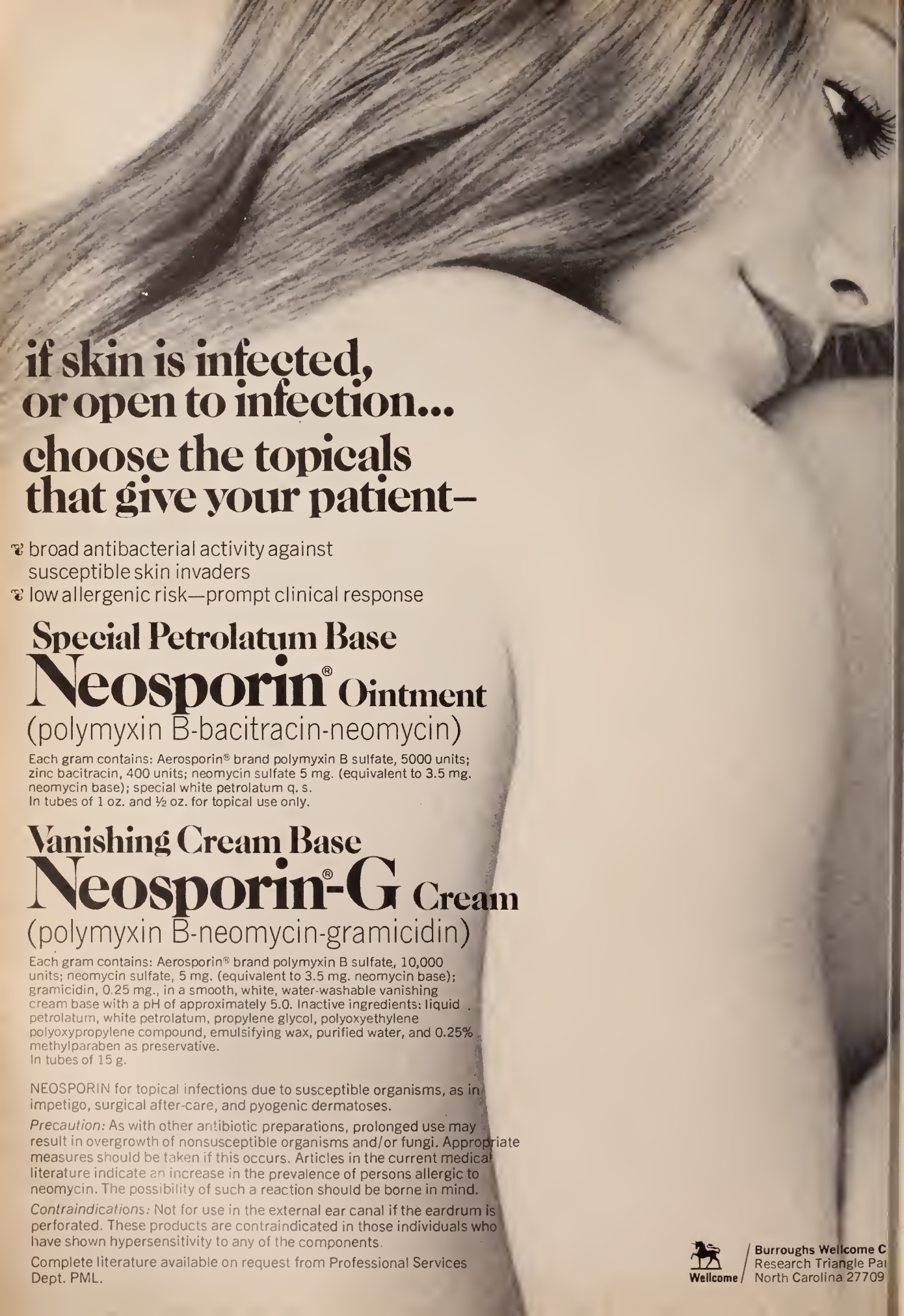
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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In tubes of 1 oz. and ½ oz. for topical use only.

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(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin[®] brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.



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Here is a step-by-step blueprint for a good emergency department, with emphasis on traumatic cases.

New Challenges in Emergency Trauma Today*

Spencer T. Snedecor, M.D./Hackensack

Nowhere in medicine are there greater pressures forcing new concepts upon us than in the field of trauma as one of the vital units of emergency medical demands. Major direction of this over the past fifteen years has witnessed the development of the emergency department of the hospital as the community center for emergency medical care. Multiple factors have accelerated the trend, and all attempts to divert it have proved futile. No alternate substitute is available.

The federal government has taken an active step in the coordination of emergency medical services through the Highway Safety Act of 1966 which provided that standards should be set up to:

1. Provide prompt discovery and response to accidents.
2. Sustain and prolong life through proper first aid measures both at the scene and in transit.
3. Provide the coordination, transportation, and communication necessary to bring the injured and definitive medical care together in the shortest practical time.

The next step is the formation of regional councils on emergency medical services. Agencies are expected to cooperate in developing and coordinating these comprehensive multiple facilities of law enforcement, ambulance service, and transportation to the hospital, two way communications between hospitals and first aid units, the development of emergency department services, and a much larger scope of teaching and training of first aid personnel.

Another current spur to this program is the

action of the Joint Commission on Accreditation of Hospitals which has come to focus on the emergency department and has approved new standards. Surveyors are instructed in the new scope and responsibilities of emergency departments which few hospitals dreamed of a year or two ago. As an outgrowth of the emergency department survey form and technique developed originally by the Trauma Committee of New Jersey and by the American College of Surgeons over the past fifteen years as a national project, the Joint Commission on Accreditation has incorporated this in a much more comprehensive survey form on a nationwide scale. We must now accent this modern challenge in the development of the emergency department of our own hospitals.

In a recent survey at our hospital one of the questions which we sought to answer was: What kind of cases were coming to our emergency department? We devised a realistic classification, cutting across departments, and found that 66 per cent of the patients coming were traumatic, 29 per cent medical, and only 5 per cent other surgical and miscellaneous cases.

Then we asked these other questions which we found to be instructive:

What kind of accidents?

How do people come?

How many cases did our *paid* staff emergency department doctors take care of in proportion to the total?

* The first Trauma Oration of the New Jersey Committee on Trauma of the American College of Surgeons, read at the 203rd Annual Meeting of the Medical Society of New Jersey, May 17, 1969, Atlantic City, New Jersey.

How many patients got x-rays?

How many patients got lab tests and what kind?

How many cases were serious in contrast to minor cases?

How many patients were serious enough to go to the intensive care unit and what kind?

How many patients went to the operating room?

How much time do our patients spend in the emergency department?

How many DOA, and other types of services?

Such special questions may be pertinent and worthwhile in your own institution, or ask for a general survey of your department by a visiting consulting team from the Trauma Committee of the American College of Surgeons and an administrator from the state hospital association. Guidelines that have helped us to improve the quality of care of these patients and to make our service more efficient follow along these recommendations.

1. *Organization of an Emergency Department.*

a. A Medical Director is essential in any busy emergency department. This was recommended by us in the handbook jointly issued by the American Hospital Association and American College of Surgeons in 1963. We urged that the Emergency Room should have departmental status with a director.

b. An ED Committee may still function helpfully on an advisory status because of the multi-department services.

c. A trauma team or service of closely cooperating specialists with a captain in charge, is needed because of the multiple-injury patient.

d. A cardio-pulmonary medical team is essential for the serious medical cases.

e. The hospital administration now assigns top personnel to this important emergency service area.

2. *Facilities for processing patients need new guidelines.*

a. Plan now for growth of 10 per cent a year and more, if you have a good department that will attract more patients. Don't get caught short three years hence.

b. The "waiting patient" is the key to efficiency. Many an ED has been enlarged just to provide waiting areas.

c. The greatest hold-up is x-ray. Extra attention needs to be focused on this service. Are proper x-rays ordered? Is the facility and technician nearby? Laboratory facilities must be readily available too.

Present emphasis in processing patients is *triage*: sorting patients promptly into separate areas, such as trauma in one section, pediatrics in another, and the critical cases (where they will receive proper and immediate first aid). Most important is a well-prepared reserve area for these critical patients.

When that bad accident case or coronary patient comes in, adequate facilities must be available immediately with a trained team to take over. Many ED's today are so busy with trivial cases that they find it hard to provide such reserve areas where proper facilities and personnel mean that a life may be saved. Rushing such patients on to the intensive care unit is unwise until they have adequate examination and initial treatment for shock and resuscitation.

3. *Staffing an ED is our most acute problem today.* More and more departments are turning to a paid medical staff and to full-time doctors. A new specialty, the emergency service doctor, appears to be arising to fulfill an important function in modern health care. Interns and residents alone no longer provide satisfactory medical service—without teaching and supervision by interested attendings *in the ED*. Processing of patients has been shown to take almost twice as long with interns and residents alone as with a paid staff.

The attending staff has certain well-recognized responsibilities that require a medical

director to implement and coordinate satisfactorily.

- a. Prompt response
- b. Privileges defined
- c. Supervision and check-up
- d. Department interest
- e. Interdepartmental coordination.

The paid staff doctors should be working under a director who will supervise their duties.

- a. Triage—examination and sorting of patients.
- b. Emergency first aid for all conditions—especially life saving measures.
- c. Administration—such as suicides, DOA, etc.
- d. Teaching—responsibility for ED personnel and also helping with ambulance attendants, and so on.
- e. Definitive care of patients as designated by the medical board in accord with their ability and type of institution.

4. *Standard operating procedures are essential in every good ED.* Administrative ones are usually available but clinical instructions are required from each department. Examples:

Eye—foreign bodies
Pediatrics—Convulsions
N & T—Nose bleeds
Dog bites
Burns
Brain Injuries

Special emergencies must be prepared for:

- a. Resuscitation—Cardio-pulmonary outline and compulsory training of all physicians, nurses, and paramedical personnel.
- b. Shock—Blood volume replacement. Cut-down, solutions, and so on.
- c. Disaster Plan—the ED is usually the center of disaster planning both in personnel and facilities.

5. *Auditing for quality control* in the ED is new—and now recommended by JCAH which specifically states that the responsibility for good records rests upon the medical

records committee of the hospital.

Three technics for audit are available:

a. A daily review of ED charts was first inaugurated by Dr. Guthbert Owens, Professor of Surgery at the University of Colorado. At our hospital we found by auditing the charts for a two month period last year that they presented the following percentages of inadequacy:

History-symptoms and physical findings	11 per cent
Record of treatment	16 per cent
Diagnosis inadequate	20 per cent
Illegible signatures	18 per cent
Illegible charts	2.7 per cent

With the current medico-legal aspect so important, better records are surely called for.

b. X-ray review offers a second method of audit and the radiology department can help in this.

c. A third and most valuable audit of trauma deaths occurring within 24 hours affords a direct reflection of the patient care in the ED. For departmental review and interdepartmental conference these audits stimulate answers to the challenging question. Could this patient's life possibly have been saved? A few years ago, we developed this audit form and processed a three-year study of acute trauma deaths in our hospital. The Trauma Committee of the ACS felt that these audits were so instructive that they approved the concept and now the JCAH has recommended this audit. Copies of the form are available through the office of ACS.

6. *The broadening function of the ED* of the hospital encompasses all aspects of community emergency service of which these four steps are significant and timely for to-day's trauma conferences on community hospital emergency services. These are also recommended by the JCAH.

a. Become a member of a regional advisory Council on Emergency Health Service.

b. Assume helpful surveillance over the quality of pre-hospital care through cooperation with ambulance personnel.

c. Arrange two-way radio communication to ambulances and all disaster units.

d. Sponsor emergency care conferences for ambulance personnel and medical staff as an educational responsibility of the hospital.

70 Hospital Place

Summary

In our rapidly growing and complex urbanizing population of today, the Emergency Health Services shine forth with increasing importance. The Emergency Department of the community hospital will continue to be the expanding hub of this essential service and the trauma patient will constitute a large proportion of the patients requiring emergency care.

When Your Child Is Sick

The Public Affairs Committee has released a new pamphlet—this one numbered 441—entitled, *When Your Child Is Sick*. It stresses the fact that only a physician is qualified to diagnose and prescribe care for a sick child. But parents, usually mothers, are responsible for seeking medical help, for carrying out doctor's orders, and for providing physical and emotional comfort during illness and convalescence. Written by Jacqueline Seaver, this pamphlet offers guidance on symptoms and situations that call for a doctor's advice or care. It is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York 10016.

The doctor's instructions may be relatively simple and often there is no cause for alarm, but Miss Seaver urges that parents always consult the doctor for any of the several listed situations. She goes into some detail on matters about which there are common misconceptions. For example, discussing fever, she stresses that mothers should "not take any steps to make a fever drop until the doctor has evaluated the situation. This applies especially to giving aspirin."

On the subject of medication, she warns that "under no circumstances should any drug or other medicine be given a child unless the doctor orders it. Prescriptions should not be

renewed unless the physician says so." And she explains the importance of strict adherence to the dosage prescribed by a doctor.

Parents should be grateful for Miss Seaver's guidance on how to give children medication matter-of-factly and help them accept illness without undue turmoil or trauma.

On emotional needs during illness, Miss Seaver counsels that "a bored child is a restless child—even a sick child should not have too much passive entertainment that requires little participation. He needs to be given things to do that make him use his mind and skills. Further, school age children should be helped to keep up with their work as soon as possible."

For parents of children going to the hospital Miss Seaver discusses how the parents can help minimize unpleasant, sometimes long-lasting emotional effects. Long-term illness or disability places heavier pressures on the sick child and on his family, and Miss Seaver considers how to avoid over-protecting the child, how to help him understand why he must take medicine, why his activities are restricted, and, at the same time, how to set realistic short-term goals that can lead to "the long-term goal of the child's becoming a self-reliant, responsible adult."

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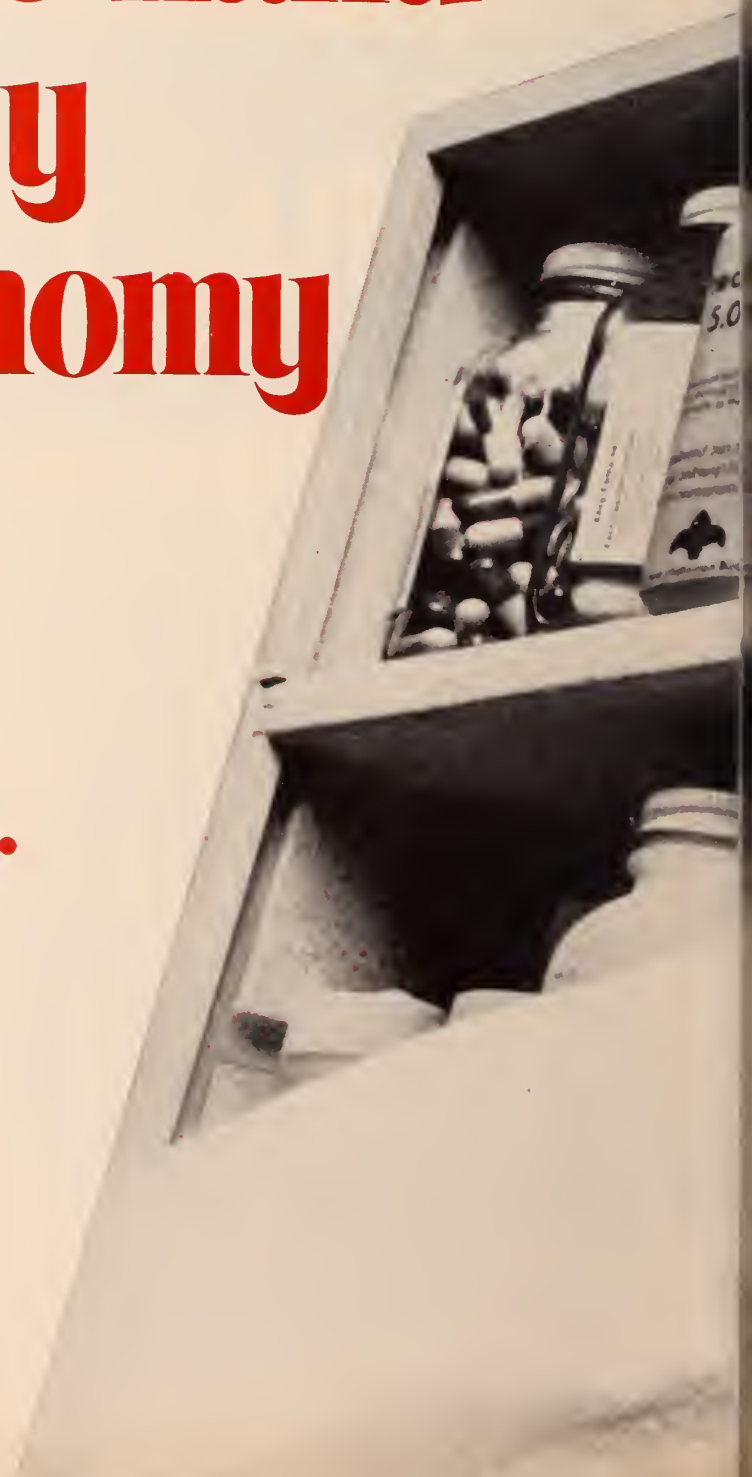
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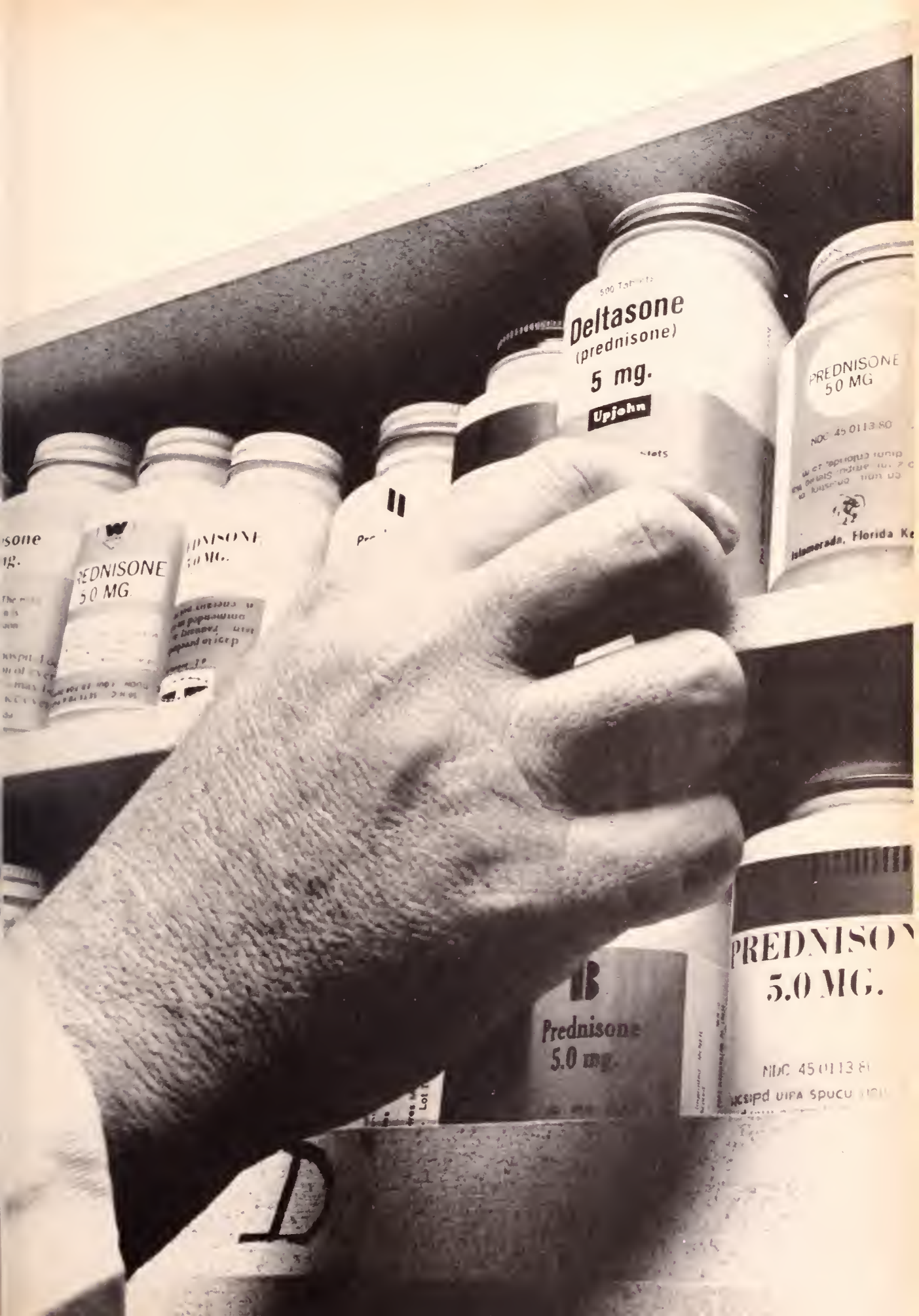
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The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. **Important:** Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccination, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and post-operative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance

doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9- α -fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoid during pregnancy, since spontaneous remission of some disease such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis an ulcer regimen and antacid are highly recommended. Take X-ray in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

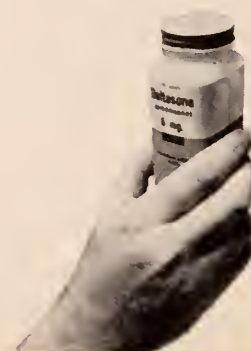
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**an economical
prednisone
that's made
a name for itself**

Authentic cases of multiple personality are extremely rare, but here is one such case.

Multiple Personality*

**John J. Smith, M.D./Greystone Park,
and Eric B. Sager/Athens, Ohio**

This is a report of a patient suffering from multiple personality (hysterical neurosis, dissociative type). Aside from the fascination of this unusual syndrome¹ and the dramatic quality of its dynamics² two other aspects of this case are of interest. We were able to administer a testing device utilizing the semantic differential to each of the three personalities early in therapy and obtained a single personality profile late in therapy.³ The treatment was carried out in an outpatient setting using third and fourth year medical students as dual therapists under supervision.

"Ann" as we call our patient, was self-referred to the outpatient psychiatric clinic of the West Virginia University Medical Center and at the time of initial evaluation by one of us (J.J.S.) was 22 years old and recently married. She complained of tension about her marriage. She was an attractive, verbal, and shy person. She felt as if "another person is viewing my actions." This had happened on two occasions. She also reported nightmares, abdominal distress, crying spells, headaches, and concern over fertility.

She had been frightened by her father who returned from the war when Ann was 15 months old. She related persistent sexual advances by her father when drunk, since she was five years old. Her mother had no knowledge of this activity and was not sought out by Ann for protection. Parental relations are described as tenuous but no overt breaks occurred. She was always a good student, dated in high school, and had several steady boy friends before marrying her husband after a

four months' courtship, a marriage of which her father disapproved. Her 19-year old brother is now in the Marines and has no known emotional problems.

A working diagnosis of "neurosis, other," was the referring reason for therapy. Also included was a dissociative reaction.

Because of a surplus of students on psychiatry clerkship she was assigned two students for an initial six week period. Subsequently this worked so well that it was continued by design because the students were more comfortable and able to supplement each other's therapeutic endeavors. It also served to split the transference.

An early point was a reported amnesia. She was told by her husband that she had called him and asked him to come immediately because "something might happen to Ann." Voluminous data support the idea that "something" refers to sexual acting out—e.g., she loves half of her father, the non-sexual. Throughout, she rejects the sexual advances of her husband but has impulses directed toward male acquaintances, co-workers, and therapists. She was becoming so anxious that diazepam,* 5 mg. t.i.d., was prescribed. After two months, a dramatic session was apparently forgotten by its close. At the next session she talked as if she were two persons, one of which wanted "to spill the beans." At the following session, the patient became a confident, flirtatious woman who identified herself as Nan: like Ann only different! This personality talked openly and aggressively about

*From the Department of Psychiatry, West Virginia University. Dr. Smith is now at the New Jersey State Hospital in Greystone Park

*Tradenamed as Valium (Roche)

sexual matters and referred to "Ann" as another person that she knew all about. Shortly, a third personality, whom we called "Ann III," emerged as an "innocent bystander"—cool, aloof, informed, and understanding. At this juncture "Ann III" was invited to ally herself with Ann against Nan.

In the next series of sessions our semantic differential was administered in the order Ann III, Nan, and Ann. Ann and Ann III write right-handed but Nan prints left-handed. Determinants were brought to light: a broken finger on the right hand and habitual use of the left hand to masturbate. We will leave the symbolism of "sinister."

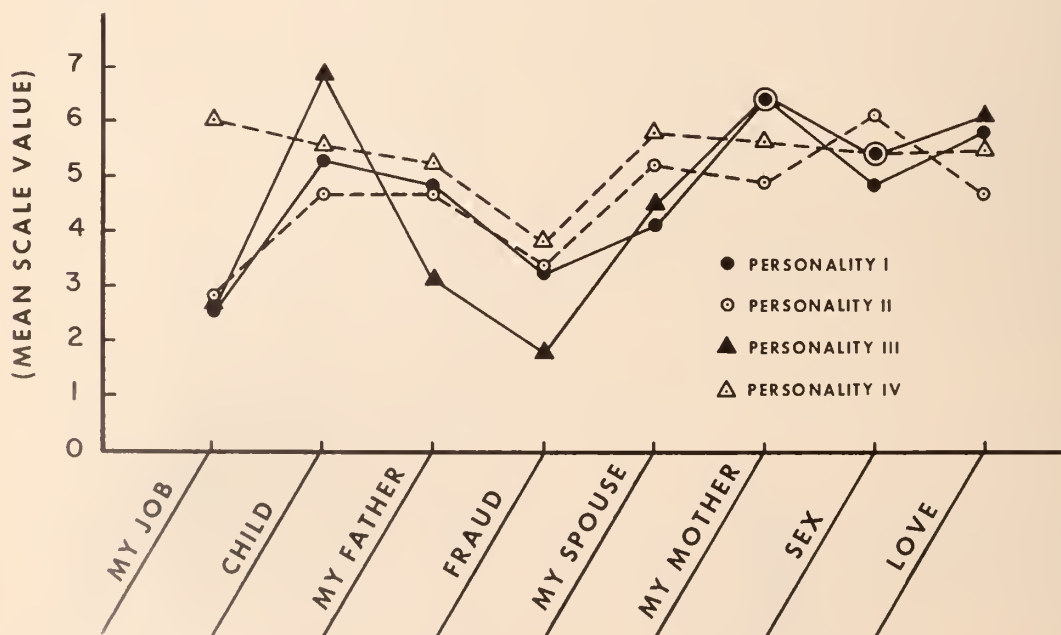
An abortive suicidal gesture was made with medication. She was rescued by her husband. A steady reintegration of the three personalities ensued with repression of Nan and a compromise personality emerging. She became pregnant and was continued in treatment through delivery of a healthy baby boy. During this period she was once again tested (Figure 1).

As the various personalities emerged we were faced with the same skepticism that Thigpen and Cleckley mention. We wondered if we were being duped by a clever actress. The only tool known to us was some sort of personality profile test that might objectify our firmly held subjective impression. We settled on a variant of Osgood's plan,³ both to convince our critics and further validate the previous work. We elected the order Ann III, Nan, and Ann to minimize spill-over of information from personality to personality—i.e., from best informed to least informed. We hypothesized that an integrated Ann after therapy would be something of a compromise.

Summary

The entity now known as hysterical neurosis, dissociative type, has intrigued clinicians from Morton Prince⁵ to the present by its dramatic quality and rarity. It has the appearance of a psycho-dynamic treasure-trove and leads one on with the hope that if this can be grasped a break-through will have

SUMMARY



This summary graph visually displays the incongruity of responses by the several personalities. Omitted is

the concept "My doctor" which in all cases was highly valued.

occurred. We regret to report no brilliant new insight. Operationally, we identified, validated, and evaluated three relatively autonomous personalities and by intercommunication have so broken down the barriers of isolation that integration as a single unit was achieved. Theoretically, one might wish to identify the symptom-ridden Ann as the *ego*, the impulsive, sexual Nan as *id* and the observant, advisory Ann III as *superego*. This is hardly more than a simplistic restatement of Freud. This may well be the real value of such a case study: that truly great insights are often utterly simple.

A case of multiple personality consisting of three well-defined parts is presented. A test-

ing device using the principle of the semantic differential was used to clarify clinical impressions of a trichotomy. The case in its outcome reminds us that student therapists can be effective if provided material that motivates them.

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New Jersey State Hospital

Appointment Of Foreign Graduates

The policy of the American Medical Association on eligibility of foreign medical graduates for appointment to approved internships or residencies continues to be as follows:

Graduates of all medical schools outside the United States and Canada should establish their eligibility for appointment to an approved internship or residency program through (a) certification by ECFMG (Education Council-Foreign Medical Graduates) on a basis of satisfactory educational requirements, as well as passing the ECFMG examination, or (b) obtaining a full and unrestricted license to practice medicine, issued by a state or other United States jurisdiction authorized to license physicians, or (c) in the case of United States citizens, successfully passing the complete licensure examination in any state or licensing jurisdiction in which the law or regulations provide that a full and

unrestricted license to practice medicine in that state or jurisdiction will be issued to the physician after satisfactory completion of his internship or residency in that state, without further examination.

In addition, to be eligible under (c) above, the foreign medical graduate must have completed all requirements that would make him eligible for ECFMG certification should he choose to apply.

The Council on Medical Education is concerned that despite these clear statements of policy of the ECFMG and the AMA, hospitals continue to permit foreign medical graduates without proper credentials to enter approved graduate medical education programs. Continuation of this practice may result in withdrawal of the approval of the program concerned.

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Immunosuppressive agents were effective antirheumatic drugs in 70 per cent of these patients.

Immunosuppressive Agents in the Treatment of Rheumatoid Arthritis*

William D. Kimler, M.D./Haddon Heights

Indications for using immunosuppressive agents in patients are: (1) active, progressive rheumatoid arthritis, (2) failure of any and all of the usual therapeutic regimens to control the activity, and (3) the willingness of the patient to have one of the agents used after full explanation of possible deleterious effects. Fourteen patients had been exposed to treatment with either 6 M.P. (6-mercaptopurine) or azathioprine (Imuran)[®]. Their ages ranged from 22 to 71. At present, there are 10 patients under active treatment. Four were discontinued because of lack of effect or intolerance to the drug. In two of these patients there was lack of effect. In two there was gastric irritation, nausea, and general intolerance. All fourteen patients met the diagnostic criteria of the A.R.A. for rheumatoid arthritis. The following selected case reports will serve to illustrate the type of patient treated and the results obtained.

Case I

A 22 year-old college student had a history of rapidly advancing rheumatoid arthritis of two years' duration. Prior treatment had consisted of salicylates, physical therapy, rest, and gold. There had been several periods of hospitalization because of fever and hip involvement. At the time she was first seen in my office her medications were Aristocort[®] and Roncovite[®]. After several months of conservative therapy, she became febrile with a temperature up to 103. Sedimentation rate rose from 21 to 57 (Westergren) and all of the peripheral joints became involved. Hospitalization became necessary as the patient became totally incapacitated. The hips worsened with flexion contractures developing. At this time the use of immunosuppressive agents was now considered. Robert Carroll, M.D., was consulted because of his

experience, as a hematologist, in the use of these agents. The proposed treatment was discussed with the patient and the family and consent obtained.

Dr. Carroll evaluated the patient hematologically and started her on Purenithol[®] 50 mgm. t.i.d. The Aristocort[®] was continued. Results were gratifying, with prompt and good improvement in the next several weeks. The patient was discharged. Purenithol[®] was given until the patient became pancytopenic in June, 1965. The drug was then discontinued and the patient transfused until her hemaporetic system recovered. Aristocort[®] was given during this time. In July, 1965, 6 M.P. was resumed at 50 mgm. daily with Aristocort[®] 2 mgm. t.i.d. The patient had an operation to correct the flexion contracture of the hip—6 M.P. was discontinued during this, with a flare in the arthritis. Resumption of treatment caused suppression of symptoms.

At present, she walks without crutch or cane, works for the Leukemia Society and, in general, leads a normal life. Her sedimentation rate stays between 57 and 68. Her present medication is Purenithol[®] 50 mgm. daily and Prednisone[®] 2.5 mgm. daily.

Case II

This patient was first seen at age 63 with a ten year history of acute joint disease. Treatment consisted of gold salts, local joint injections, physical therapy, and blood transfusions. When first seen, sedimentation rate was 120 (Westergren), hematocrit was 33, hemoglobin, 11.5 gm; and WBC 9,450. R.A. Latex Test was strongly positive. His general condition was fair, with no good remission of the disease at the time he was admitted to the hospital for a transurethral prostatectomy. Following discharge from the hospital the joint disease gradually worsened. A few months later it was necessary to admit the patient to the hospital as he had reached the point of being unable to walk except with crutches and then only with the greatest difficulty. He became bedfast and practically immobile from involvement of the joints and the pain. Dr. Carroll prescribed Purenithol[®]. When the white count dropped from 14,700 to 2,850 Aristocort[®] was added to the regimen. A transfusion was given when the hemoglobin level was 9. The patient was also

* Read before the Sections on Radiology and Rheumatism, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1971.

given analgesics and local joint injections. A month later, he was discharged and there was marked symptomatic improvement. He is still taking Purenithol® and a small dose of corticosteroids daily under Dr. Carroll's direction. Symptomatically he is almost totally in remission. There is an occasional twinge of pain in a peripheral joint, but this is transient. (Anyone who can clean the gutters on a two story house, using a forty foot ladder alone, must certainly be somewhat improved.) The peripheral blood picture is reasonably good, with hemoglobin 11.8, hematocrit 37 per cent and a 8,800 leukocyte count. Sedimentation rate is fixed at or near 90 to 110 (Westergren).

Case III

A 46 year-old woman was first seen in January, 1969. Duration of rheumatoid disease was 15 years. An adequate trial of gold and salicylates has been given by Georgia Allen, M.D. The patient had had corrective surgery on the hands in 1966. By now pain was constantly present and the deformities were progressing. She was referred for possible Imuran® therapy. After hospitalization and a hematologic survey by Dr. Stuart Blum, Imuran® was started. The drug was well tolerated and the patient was discharged to office care a month later.

The laboratory findings of interest in this case are: sedimentation rate was 12 (Westergren) and 27 two years later. Hemoglobin was 13 at the start of treatment and the last determination was 14.5. Total white count has declined from 13,300 to 7,200. The platelet count is about 200,000. The R.A. Test is strongly positive. Dr. Blum evaluates the blood periodically with counts every three weeks. There has been almost complete relief of pain. She has complaint of an occasional transient twinge in a peripheral joint. Morning stiffness has completely subsided. Medication is Imuran® 50 mgm. t.i.d. No corticosteroids are being prescribed.

The remaining patients in this series have variable amounts of relief governed by their ability to take immunosuppressive agents. Should the blood picture decline with a marked fall in platelets and white count, the Imuran® is reduced or discontinued. There seems to be a relationship to the dosage. On reduced dosage (or on discontinuing the medication) the patients' complaints return.

Failures

A 53 year-old male with severe spondylitis and peripheral arthritis was unable to tolerate the medication because of marked gastric irritability with nausea and vomiting.

A 42 year-old female developed a marked anemia requiring transfusion. There was no gain in joint improvement from Imuran®. The anemia came as a surprise. Because of tubular vision on my part, I was intent on watching the white cell and platelet counts.

Two females did not respond even though the drug was tolerated.

Summary

Fourteen patients were treated with immunosuppressive agents with excellent to fair response in ten. Four patients were discontinued, because of intolerance to the drug or gastric distress or nausea, or because of effects upon the hemaporetic system.

In the light of reports of possible causation of lymphomas in patients on immunosuppressive therapy, and the general lack of good knowledge about the mechanism of this approach to the treatment of rheumatoid arthritis, it is suggested that marked caution be used and very serious thought taken before embarking on this course.

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The Glucagon Growth Hormone Stimulation Test

Richard Fogel, M.D./East Orange

A defect in growth-hormone release is often the initial functional impairment noted in patients with panhypopituitarism.¹ The possibility of isolated growth-hormone deficiency frequently must be considered in short-statured, but otherwise normal children. Thus, there seems to be a need for a simple and reliable method of evaluating growth-hormone release. Fasting values of growth hormone in normal people may be low. Measurement of growth hormone in the fasting state, therefore, is not an adequate measure of anterior pituitary function or growth hormone responsiveness.¹

An appropriate stimulus is required to cause growth hormone release. Until recently, growth hormone measurement after insulin-induced hypoglycemia² or after intravenous arginine^{3,4} were the only reliable methods. Both techniques have obvious drawbacks. Insulin and arginine are administered intravenously. Hypoglycemia (induced during the insulin procedure) can be hazardous, requiring careful attendance. Furthermore, arginine monochloride is available only as an investigational tool. On the other hand the intramuscular administration of glucagon⁵ is a method of stimulation growth-hormone release that I have found to be quite satisfactory.

This report concerns an evaluation of the glucagon-growth-hormone procedure in short-statured children. The subjects were fifteen children who were short-statured but otherwise had no other obvious endocrine disorder. In addition, three patients with proved

Growth Hormone Studies

	90 Minutes	120 Minutes	150 Minutes
• (M) . . .	3.3 NG/ML	5.0 NG/ML	2.8 NG/ML
•• (F) . . .	0.8	0.2	0.5
(F) . . .	1.0	6.3	17.0
(M) . . .	1.0	10.0	14.8
• (M) . . .	3.0	1.8	1.5
••• (M) . . .	42.5	30.3	14.3
(M) . . .	5.0	9.3	8.0
(M) . . .	0.7	7.3	3.7
(F) . . .	1.2	17.3	11.4
(M) . . .	7.3	7.5	7.7
(M) . . .		7.7	5.5
(F) . . .	0.3	7.5	5.0
(M) . . .	6.6	17.3	10.5
(M) . . .	9.8	9.7	3.0
(F) . . .	3.2	35.8	12.0
(F) . . .	4.3	30.5	26.6
(F) . . .	4.1	21.2	10.0
(M) . . .	14.0	9.3	6.2

- post-surgical panhypopituitarism
- isolated growth-hormone deficiency
- Vitamin D deficient rickets

growth hormone deficiency were also tested. All were fasted overnight. Basal samples were obtained in the early morning (8 to 8:30 a.m.). After the sample was drawn, 0.5 to 1 milligrams of glucagon were injected intramuscularly; the amount of glucagon was based on body weight. Blood was collected at 90 minutes, 120 minutes and 150 minutes after glucagon injection. Serum was separated and frozen until assayed.[†]

Radio-immunoassay was performed in duplicate by the technic of Glick, *et al.*,⁶ with modifications. No side effects were noted subsequent to glucagon injection.

The table shows the mean values of growth hormone at various times after glucagon injection. The minimally accepted value indicating responsiveness was 7 nanograms per

[†]Performed at RLF Bio Analytic Laboratories (Endocrine-Radioisotope Laboratories, East Orange)

milliliter^{5,7} In those patients with growth-hormone deficiency (later substantiated with insulin-induced hypoglycemia testing), no elevation in growth hormone was noted.

Conclusions

The glucagon stimulation test appears to be a simple, effective, and reliable method of evaluating growth-hormone release in children, as well as in adults. Commercial glucagon is readily available and relatively inexpensive. It is important to note the maximum elevated growth hormone values occurred most frequently at 120 minutes. Previous failure to document the growth hormone response after glucagon administration may have been due to measurements of growth hormone at too early a time. Glucagon causes growth-hormone release independent of the level of the blood sugar, since elevation of the growth hormone occurs at times before the blood sugar value declines.^{3,6,7}

The glucagon stimulation test should be regarded as an effective screening procedure when used to detect a deficiency of growth-

hormone release both in isolated growth hormone deficiency and in panhypopituitarism.

Earlier testing with this simple procedure might well lead to earlier diagnosis and treatment. Failure to obtain growth-hormone elevations in response to glucagon administration may imply the need for further testing utilizing the hypoglycemic stimulus to growth hormone release.

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AMA Statement on Venereal Disease

The American Medical Association reports that gonorrhea ranks first and syphilis third among the reportable communicable diseases in the U.S.A. For the year ending June 1970, infectious syphilis rates were eight per cent higher than a year earlier. At the same time gonorrhea morbidity exceeded 573,000 reported cases. Gonorrhea is pandemic in the United States, with an estimated two million cases.

The Council urges all physicians to be sensitive to the growing and alarming dimensions of the VD problem. Physicians in private practice treat 80 per cent of all syphilis and gonorrhea but report to public health departments only one out of every eight cases of syphilis and one out of every nine

cases of gonorrhea they treat. Physicians should assist public health departments by reporting these VD cases. Much effort must still be made by health departments and medical societies to foster mutual trust so that public and private medicine can work effectively for the control of syphilis and gonorrhea. Medical societies should continue efforts for the enactment of state laws to permit physicians legally to treat VD cases of minors without obtaining parental consent. Most now have laws which permit physicians to treat a minor for VD without adult consent. Also, medical societies are asked to support education of patients and the public through more extensive and imaginative use of all available media and through school curricula.

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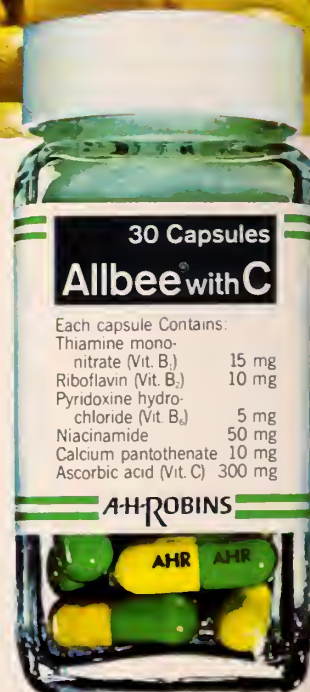
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Although generally thought of as an inpatient procedure, methadone maintenance may be induced in a day center under the precautions here spelled out.

Rapid Induction Of Methadone Maintenance In Heroin Addicts

Hans W. Freymuth, M.D., et al. Trenton*

The first phase of methadone maintenance therapy is identified as induction or "loading." It consists of administering daily oral doses of methadone in gradually increasing amounts over a period of approximately three weeks, until a daily level of about 100 milligrams has been reached. Patients can then generally be maintained at a constant, daily dose for prolonged periods of time without the need for further changes.

With completed induction, two major goals have been met:

1. The patient's opiate hunger is satisfied. This hunger appears to be almost irresistible to most opiate addicts. Clinical evidence and laboratory studies on animals suggest that it is *not* purely psychological and may have its basis in a metabolic defect, which seems to develop with regular opiate use. Once developed, it appears to be of an almost irreversible quality. This drug hunger can be satisfactorily controlled with the use of a substitute opiate like methadone.

2. Heroin blockade is induced. Daily oral intake of 100 milligrams of methadone produces a high degree of tolerance as well as cross-tolerance to other drugs of the opiate family, including heroin. This cross-tolerance makes the patient relatively immune to the effect of heroin while he is on methadone maintenance. Heroin blockade is the second important factor in controlling these patients.

Induction is preferably conducted as an inpatient procedure. If on an out-patient basis, certain dangers must be faced. Before the patient has reached a daily level of 60 to 80 milligrams of methadone, cross-tolerance is not sufficient to offer protection against the effects of heroin. Until he has reached this level, there is a definite danger that the methadone may become a "pump primer" for his heroin habit. If small, non-blocking doses of methadone are used too long, a significant number of heroin addicts develop an iatrogenically induced pattern of combined methadone and heroin addiction. This offers certain advantages to them. They need somewhat less heroin than they would without the "pump priming" effect of methadone to produce the desired "high" or euphoric state. Short interruptions of heroin use lead to less severe and painful withdrawal syndromes, if oral methadone intake is continued during such time.

The danger of developing such a pattern of double addiction increases in proportion with the length of time a patient is receiving small, non-blocking amounts of methadone during the earlier part of his build-up. Therefore, out-patient induction should be completed as rapidly as possible.

It was the purpose of our study to observe closely the reactions of a small number of addicts exposed to a very rapid build-up schedule, with the goal of reaching 100 milligrams

*Coauthors are Hospicio L. Garcia, M.D., New Jersey Neuro-Psychiatric Institute, Skillman, New Jersey, and Esther Suozzo, R.N., Trenton.

of methadone daily within a ten day period. The study was conducted in an in-patient facility.¹ We included only patients with a low opiate tolerance at the onset of their build-up period, and, therefore, only those with a confirmed abstinence ranging from three to eleven weeks preceding induction were included.

Three male and three female heroin addicts were selected. They ranged from 21 to 41 years of age, all with a long and carefully documented history of addiction. They underwent meticulous physical examinations and laboratory studies prior to induction. None showed major pathology. One male (age 31) had a moderate hypertension of 150/96 and one female had a history of hypertension, although her blood pressure was only 138/60 at the time induction was started.

The following induction schedule was used:²

First Day: 20 mgm. of methadone in two divided doses, separated by more than 4 hours.

Second Day: 25 mgm. of methadone consisting of one dose of 15 mgm. and a second dose of 10 mgm., separated by more than 4 hours.

Third Day: 30 mgm. of methadone consisting of one dose of 25 mgm. and a second dose of 5 mgm., separated by more than 4 hours.

Fourth Day: 40 mgm. of methadone in one single dose, given not less than 20 hours after the last dose of the previous day.

Fifth Day: 50 mgm. of methadone in one single dose, given not less than 24 hours after the dose of the previous day.

Sixth Day: 60 mgm. of methadone in one single dose, given not less than 24 hours after the dose of the previous day.

Seventh Day: 70 mgm. of methadone in one single dose, given not less than 24 hours after the dose of the previous day.

Eighth Day: 80 mgm. of methadone in one single dose, given not less than 24 hours after the dose of the previous day.

Ninth Day: 90 mgm. of methadone in one single dose, given not less than 24 hours after the dose of the previous day.

Tenth Day: 100 mgm. of methadone in one single dose, given not less than 24 hours after the dose of the previous day.

Rapid induction caused a number of side reactions, some of which were temporarily observed in all six patients. In three, they were not serious enough to interfere. The other three developed side reactions serious enough to make a modification of the induction schedule necessary.

Side Reactions

1. Constipation appeared generally on the second or third day. This was successfully controlled with milk of magnesia and cascara. It affected all six patients.

2. Diaphoresis, which at times was quite marked, was also observed in all patients.

3. General pruritus was moderately severe in two patients. This pruritus was not accompanied by visible skin changes and was mitigated with calamine lotion. One case of pre-existing acne became aggravated.

4. Episodes of over-sedation, marked by nodding, sluggishness, unsteadiness of gait, and slowing of respiration without changes in pulse rate, were subjectively experienced as agreeable by most of the patients. They could be easily aroused and remained responsive to mild external stimuli. One male patient developed a more severe over-sedation syndrome with marked slowing of the respiratory rate.

5. All patients experienced episodes of nausea. Three of them vomited. This was treated with bed rest. It was not severe enough to be seen as a contra-indication against continuation of rapid build-up.

6. Dryness of the mouth was observed in all patients. It became severe in one, with cracking and crusting of the lips.

7. Frontal headaches occurred in all six patients. They were generally mild and most

¹New Jersey Neuro-Psychiatric Institute at Skillman, New Jersey.

²This schedule is not recommended for routine use.

pronounced in the afternoon and responded to aspirin or similar mild analgesics.

8. Weight changes, ranging from two to eight pounds, were observed in all six patients. One female (who had developed considerable edema) gained eight pounds. Another female gained four pounds, and the third female gained two pounds. Of the three males, two gained five pounds and three pounds respectively, but the third lost three pounds. He showed generally unfavorable response to rapid build-up and his schedule had to be modified.

9. One side reaction (observed in four of the six patients) was excitement with mood changes ranging from euphoria to depression. During these episodes, the patients showed varying degrees of talkativeness, elation, irritability, aggressiveness, and general instability of mood. This particular syndrome appeared mostly on the third to sixth days of induction, after these patients had reached a level of 40 to 60 milligrams daily. It tended to precede episodes of over-sedation.

One patient developed an upper respiratory infection during induction, which was treated with tetracycline without interruption or modification of his induction schedule.

All these reactions were temporary. All the side effects disappeared several days after maintenance levels had been reached, with the exception of constipation and hyperhidrosis, which continued to a varying degree for some time following the completion of induction.

Of the three patients whose schedules had to be modified because of more serious side reactions, two had developed an increase in blood pressure. They included the male who had shown hypertension prior to onset and the female with a history of hypertension. The male's blood pressure rose from 150/96 at the beginning of induction to 200/110. The female with a beginning blood pressure of 138/60 showed a raise to 154/110. In addition,

these two patients developed considerable pitting edema of feet and ankles, which responded to hydro-diuril.

Another male showed weight loss, more severe signs of over-sedation, and considerable nausea with vomiting and dehydration with cracking of the lips, making a longer induction schedule necessary. He was the only patient in the group who showed weight loss during induction.

None of the six patients required more than fifteen days for completion of induction and all six are now successfully established on methadone maintenance.

Summary and Conclusions

Six opiate addicts with low tolerance were subjected to rapid methadone maintenance induction and showed a number of side reactions, which are here described. Reactions were not serious enough to interfere with a ten day induction schedule to maintenance levels of 100 milligrams daily in three of the six patients. In three others, an extension of induction time became necessary. Induction of all six patients was successfully completed within fifteen days.

All patients showed temporary interference with alertness. Some had considerable mood changes during induction. We concluded that it was inadvisable and dangerous for patients undergoing rapid, ambulatory induction to drive or to be exposed industrially during induction time.

The frequency of side reactions during rapid built-up indicated that ambulatory induction should be conducted in a day care center setting, allowing for the patient's arrival in the morning and return to his home in the afternoon. This provides the amount of supervision necessary to conduct ambulatory induction in good medical judgment.

Frequent urine monitoring is important during ambulatory induction, inasmuch as concomitant use of other opiates may be danger-

ous, may interfere with the induction procedure, and could lead to a combined methadone-heroin habit.

While the side reaction in a considerable proportion of patients without tolerance to

opiates became too severe to make a 10-day build-up schedule practical, a 15-day schedule appears to offer a good compromise between the clinical need for rapid ambulatory induction on one hand and avoidance of major side reactions on the other.

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The Hospital Emergency Command System was designed and developed by the Emergency Care Research Institute and is supported by a grant from the United States Public Health Service. Demonstration systems are operating in two Philadelphia-area hospitals. The Institute is a non-profit foundation with no financial interest in HECS. HECS planning kits are offered by the Institute to hospitals to help them specify their requirements to local suppliers. If interested in looking into this for your hospital, write Emergency Research Institute at 913 Walnut Street, Philadelphia 19107.

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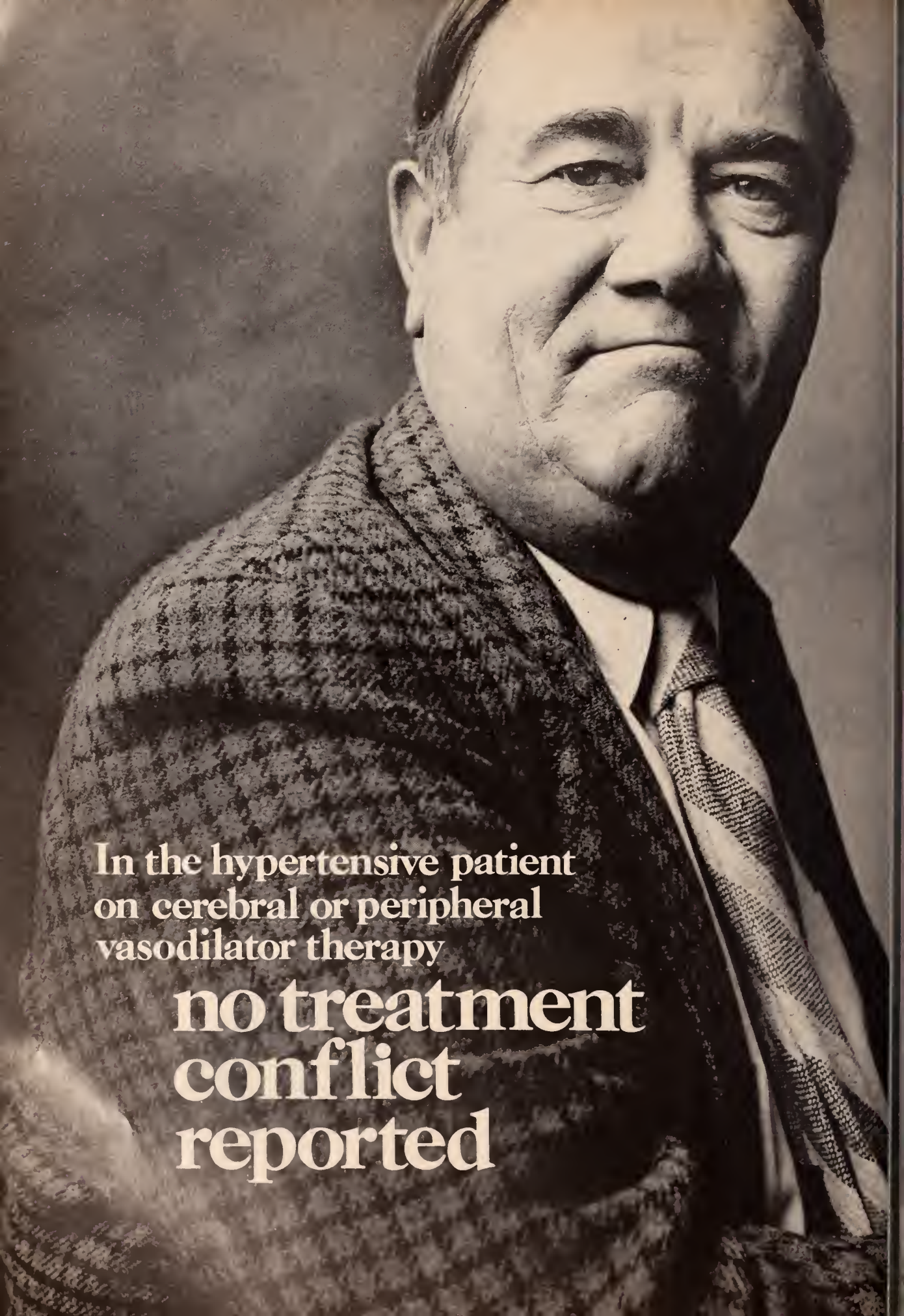
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Warren H. Foer, M. D., et al./Teaneck

In certain conditions (typified by cancer, due to the pathological processes) chronic or intractable pain may develop. The control of pain then becomes a major therapeutic problem in itself. Too frequently, analgesics including potent narcotics fail to provide even temporary relief despite ever-increasing doses. In an attempt to alleviate the pain, numerous surgical procedures have been devised to disrupt the pain pathways at some point in its course to conscious perception.

In 1912, Spiller and Martin¹ reported on open cordotomy with section of the lateral spinothalamic tract in the ventral quadrant of the spinal cord. This tract conveys pain and temperature sensation from the contralateral half of the body. Although effective, it is a major operative procedure requiring general anesthesia and laminectomy. Thus, debilitated patients are frequently excluded. Formidable risks are involved as well. Mortality rates up to 10 per cent with unilateral and 30 per cent with bilateral cervical procedures have been reported. Respiratory arrest and vasomotor collapse may occur. Permanent motor paralysis² and urinary bladder dysfunction³ occur in up to 20 to 50 per cent of patients.

In 1963 Mullan⁴ first reported on the percutaneous destruction of the spinothalamic tract in the spinal cord by means of a strontium⁹⁰ needle implant. Rosomoff⁵ subsequently modified this by using a radiofrequency co-

agulation current to produce the destructive lesion. This latter procedure (known as percutaneous cervical radiofrequency cordotomy) has subsequently proved to be a simple, highly effective, and relatively safe means of alleviating intractable pain in a wide variety of disease states.

The operation is carried out under local anesthesia (xylocaine®) in an awake but lightly sedated patient. In our hospital it is performed in the special procedures suite of the Radiology Department where an omnidirectional fluoroscopic image intensifier system is available. This is used for guidance of the needle to the target: the lateral spinothalamic tract in the ventral quadrant of the spinal cord.

The patient is placed in the supine position on the x-ray table with the head affixed in a special cupped head holder. Following sterile preparation, an 18 gage thin-walled spinal needle is inserted into the lateral aspect of the neck opposite the intralaminar space between the first and second cervical vertebra (see figure 1). Under fluoroscopic control, the needle is directed into the spinal canal in a fashion similar to a spinal tap until the dura is punctured with release of cerebrospinal fluid. The position of the spinal cord is outlined by injecting 10 cubic centimeters of

* From the Department of Neurological Surgery at the College of Medicine and Dentistry of New Jersey and the Departments of Surgery at Hackensack Hospital, Holy Name Hospital, and Pascack Valley Hospital. Coauthors are Peter R. Pillone, M.D., George B. Jacobs, M.D., and Rosanne Mazzola, R.N.



Figure 1—Initial insertion of needle into lateral aspect of neck opposite first and second cervical vertebrae.



Figure 2—Following injection of air, anterior border of spinal cord (arrows) is outlined. Needle is directed toward target zone.



Figure 3—Electrode top (arrow) extending beyond needle into spinal cord as seen on AP view.

filtered air. Critical adjustments are then made with a stereotactic micro-manipulator which is attached to and directs the needle toward the target zone (see figure 2).

A premeasured partly insulated 0.020 inch stainless steel electrode is inserted through the needle into the spinal cord at the projected site of the pain pathway (see figure 3). A controlled discreet lesion is made with radiofrequency coagulation current. (RFG-2A System—Radionics, Inc.) As destruction of the spinothalamic tract proceeds, a rising level of analgesia, as determined by loss of perception of pin prick, becomes evident on the contralateral aspect of the body. With satisfactory destruction of the pain pathway instantaneous abolition of pain occurs. Upon completion the needle and electrode are withdrawn and the patient returned to his room.

Average operative time is 25 minutes. Only one side is done during a single operative session. Bilateral pain problems require a staged procedure; the second side is performed a week following the first. Hospitalization has been reduced considerably in comparison to that following the open procedure, usually 4 to 5 days with a unilateral and 12 to 14 days with a bilateral procedure.

Personal Experience

We have done percutaneous cordotomies in 30 patients ranging in age from 32 to 86. The intractable pain was produced by a wide variety of pathological conditions as listed in Table 1. Metastatic disease accounted for 70 per cent of our patients. Lung, breast, and prostate were the most frequent primary sites. Pain involved the upper extremity of thorax in eleven patients; the back or lower extremi-

TABLE I
DIAGNOSIS

MALIGNANT—21 Patients		BENIGN—9 Patients	
	70%		30%
Lung	7	Post herpetic neuralgia	3
Breast	3	Degenerative discogenic disease post multiple operations	2
Prostate	3	Post thoractomy incisional	1
Gastrointestinal	2	Osteoporosis with vertebral collapse	1
Renal	1	Phantom limb	1
Osteogenic sarcoma	1	Multiple sclerosis with contractures	1
Tongue	1		
Primary unknown	3		

ty in 19 patients. Six patients had bilateral pain involvement. Thirty-seven cordotomies were carried out to completion, including six bilateral and four repeat procedures for fading of the sensory levels. In two patients the procedure was terminated prior to completion because of poor cooperation. In only one patient were we unable satisfactorily to disrupt the spinothalamic tract despite two attempts.

Results are listed in Table II. Satisfactory relief of pain was obtained in 90 per cent of the patients with 17 (57 per cent) enjoying complete relief and ten (33 per cent) getting partial relief. In those patients with partial relief, residual pain required minimal, if any, non-narcotic analgesics for control.

TABLE II

<i>RELIEF OF PAIN</i>	<i>Per cent</i>
27/30 Partial to complete	90
17/30 Complete	57
10/30 Partial (mild analgesics required)	33
3/30 None	10

Complications as listed in Table III have been gratifyingly low.

TABLE III
MORTALITY AND MORBIDITY
IN 37 PROCEDURES:

Death	1
Paresis	4
Urinary Bladder Dysfunction	4
Respiratory Dysfunction	1
Vasomotor Collapse	0
Ataxia	8

One death occurred related to the procedure. This was a patient with far advanced bronchogenic carcinoma. Urinary retention occurred in four patients, usually following a bilateral procedure. In all instances, this was temporary with two patients requiring only single catheterization. The other two required Foley catheters for one week and one month respectively. Transient weakness was noted in three patients. One patient has had mild residual weakness.

Ataxia of the ipsilateral lower extremity is frequent. This is felt to represent involvement of the ventral spinocerebellar tract which lies adjacent to the pain pathway. We did not have a single case of vasomotor collapse in our series.

A potentially lethal complication is that of sleep induced apnea with arrest of spontaneous automatic respiratory activity during sleep. The pathophysiology remains unclear but may represent a deafferentation of the medullary respiratory centers.⁶ This most commonly occurs following bilateral procedures. In view of this potential complication, all patients considered for cordotomy undergo a full battery of pulmonary function studies prior to and after the procedure. As yet there are no fully reliable parameters to predict which patients may develop this syndrome. Those with impaired functions are more susceptible.⁴ As a precaution, all patients who undergo bilateral procedures (or whose precordotomy pulmonary function studies show significant impairment) are placed in

the intensive care unit post operatively where close observation and respiratory monitoring are maintained. If signs of respiratory dysfunction become apparent prompt endotracheal intubation or tracheostomy with artificial ventilation will carry the patient through the acute phase until automatic respiratory activity returns. In our series only one patient following a staged bilateral procedure developed transient respiratory distress. This did not require any active treatment.

In comparison with open cordotomy, the percutaneous method has resulted in a marked reduction in both morbidity and mortality.

Our experience along with others^{7,8,9} has shown that percutaneous cordotomy is an effective means of alleviating intractable pain in a wide variety of disease states. Its effectiveness, however is limited to spinothalamic tract mediated "pain" sensation. Other discomforting sensations such as dysesthesiae, burning, pressure, or spasm are not affected. Careful patient selection requires a thorough interview to clarify the nature of the discomfort, and ascertain its amenability to spinothalamic tract disruption. At times this may be difficult due to the common tendency to describe all discomforts as "pain." Not infrequently, many components, including dysesthesiae, as well as physiologic pain, combine to produce the patients over-all state of distress. However, with proper patient selec-

tion and full patient awareness of the limitation of the procedure, extremely gratifying results are obtainable.

Percutaneous cordotomy has been particularly useful in patients with intractable pain secondary to metastatic disease. The relative simplicity of the technic allows even severely ill patients to undergo the operation, and thus, during their terminal stages of their diseases, be pain free. In those with less advanced states or with benign disease, pain frequently produces a functional incapacitation. With relief from intractable pain resumption of normal activity is possible.

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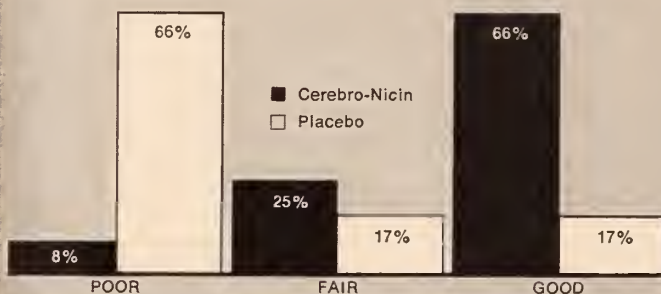
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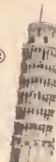
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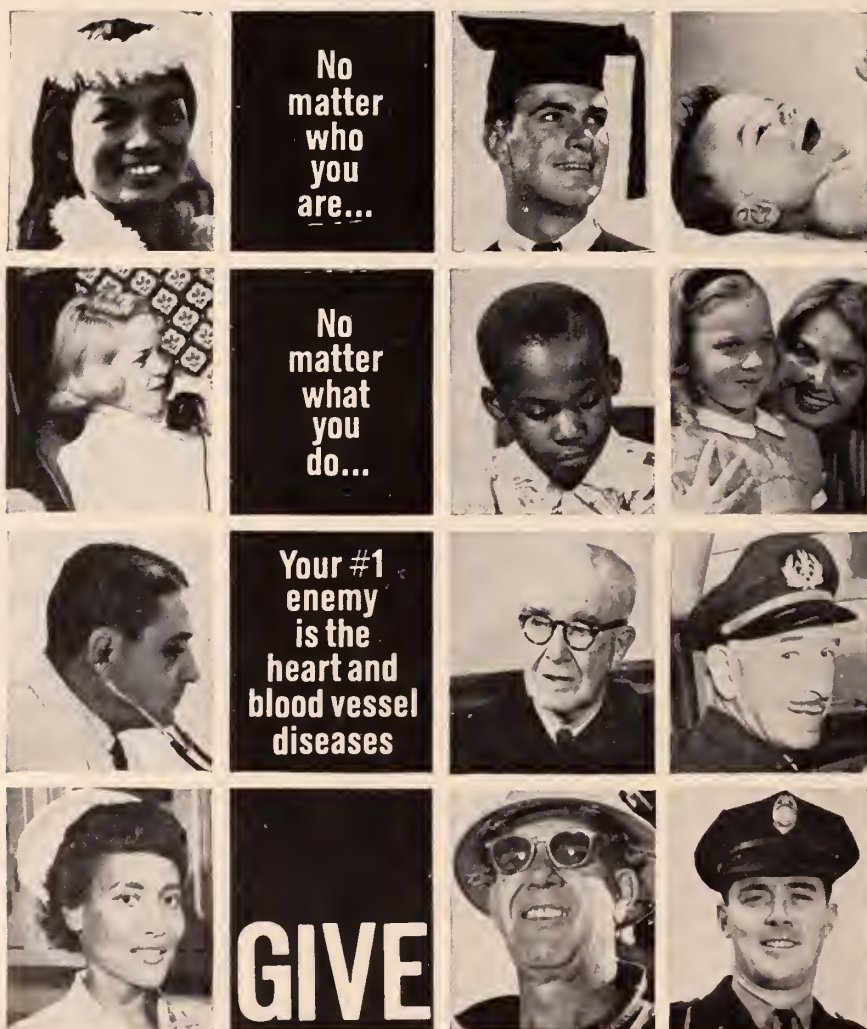
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and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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Specific therapy for night leg cramps

For certain aspects of controlling the disability, amantidine seems more effective than L-Dopa in parkinsonism.

Amantidine for Relief of Parkinsonian Tremor*

Elmar G. Lutz, M.D./Wayne

New horizons in the pharmacotherapy of neurologic diseases have been opened by the introduction of penicillamine for Wilson's disease and the introduction of carbamazepine for the control of trigeminal and glossopharyngeal neuralgia. These developments were followed by the response of paralysis agitans to L-Dopa therapy.

Parallel to this latter event occurred the chance discovery by Schwab, *et al.*¹ of the therapeutic effectiveness of the antiviral agent amantidine hydrochloride (Symmetrel®) in Parkinson's disease. Schwab¹ and his colleagues had encountered a woman with moderately severe Parkinson's disease, who had a remarkable symptomatic remission on taking 100 milligrams of amantidine twice daily to prevent A2 influenza. Parkinsonian symptoms returned on stopping the drug after six weeks. Then 163 parkinsonian patients (98 were males) were treated, ages 35 to 84. Each took 100 milligrams of amantidine after breakfast for six days and a second capsule after lunch. Improvement occurred during amantidine therapy in 66 per cent of the patients, a ratio interestingly similar to L-Dopa treatment results. Symptom reduction usually occurred in akinesia, rigidity, and tremor.

The following case reports concern my experience with amantidine in early cases of parkinsonism with tremor as the main presenting and disabling symptom. In all three patients the effect of amantidine is maintained.

Case One

A 55-year-old woman experienced progressive tremor in the left leg since January 1970. This tremor, present at rest, became accentuated by emotional excitement. It subsided during sleep. There was no known history of neurologic or mental disease in the immediate family. The tremor at rest was confined to the right lower extremity, together with minimal cogwheeling. Her face was somewhat expressionless. There was diminution of associated arm movements on the left. In May 1970, amantidine (Symmetrel®) †, 100 milligrams twice daily, was given. Within two weeks the tremor had disappeared. However, a subjective sensation of tremor persisted. In August 1970, amantidine (Symmetrel®) † was increased to 100 milligrams three times daily with further decrease in subjective sensation of tremor and complete disappearance of cogwheeling. Up to the present time patient is objectively asymptomatic as far as tremor and cogwheeling are concerned. Livedo reticularis to a mild degree occurred on both forearms in November 1970 with the beginning of cool weather. No other side effects were observed.

Case Two

A 54-year-old man plunged into a depression in December, 1967. This paralleled the development of tremor in both hands. His past history included a difficult delivery with a birth weight of 14 pounds and a left facial tic dating back to infancy. He had been exposed to mercury vapor for twelve years. Numerous psychiatric treatment measures resulted in only temporary and minimal improvement. His tremor had increased during periods of phenothiazine treatment. Neurologic examination disclosed moderate tremor in both hands, somewhat more on the right, with some cogwheeling in both arms. Facial expression (except for frequent left-sided facial tics) was fixed and there was a positive Myerson's sign (glabellar tap reflex). In June 1970 treatment with Symmetrel® †, 100 milligrams twice daily, was instituted. This resulted in complete control of the finger tremor in both hands within two weeks, diminishing cogwheeling over a period of eight weeks and disappearance of the glabellar sign within three months. Up to the present time, patient is asymptomatic as far as tremor is concerned, except for minimal tremor on arising in the morning which subsides following

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†Symmetrel® is the tradename given by E.I. duPont de Nemours Company of Wilmington, Delaware, to their brand of amantidine hydrochloride.

first daily dose of amantidine. Cogwheeling in both arms is minimal and intermittent. Livedo reticularis or other side effects were not observed.

Case three

A 49-year-old introverted woman, plagued by life-long fears and neurasthenic symptoms, experienced vertiginous episodes and bilateral leg tremor since fall 1967 following a stressful employment situation. She had not received any phenothiazines. There was a family history of Meniere's syndrome. She showed marked tremor at rest and mild rigidity in both lower extremities, mild cogwheeling in both arms, propulsive gait, and a positive glabellar sign. Diphenyl hydantoin, given after the finding of paroxysmal cerebral dysrhythmia markedly diminished the occurrence of the vertiginous episodes and associated light sensitivity. However, the bilateral leg tremor persisted. In October 1970 Symmetrel®† treatment, 100 milligrams twice daily, was begun. This measure resulted in near complete objective control of the leg tremor and complete control when Symmetrel®† dosage was increased to 100 milligrams three times daily. No livedo reticularis was observed.

Since symptomatic control of the resting tremor with amantidine was achieved in these cases up to the present time, no attempt was made to institute L-Dopa therapy following its release by the Federal Food and Drug Administration.

Goodwin-Austen, *et al.*² in their L-Dopa study observed that akinesia improved more than rigidity and that tremor did not improve. This is in contrast to the study of Yahr, *et al.*³ who reported that rigidity, tremor, and akinesia were all significantly benefited. This apparent difference could be explained through the fact that the treatment period in Yahr's study³ was considerably longer than in the series reported by Godwin-Austen.²

The general impression is that tremor yields less consistently (and later in the course of treatment) to L-Dopa than do akinesia and rigidity. Siegfried, *et al.*⁴ treated one hundred patients with Parkinson's disease for one year with a combination of L-Dopa and a decarboxylase inhibitor. This improved the intestinal absorption of L-Dopa and also facilitated passage of the drug through the blood-brain barrier, allowing the therapist to reduce the therapeutic dosage of L-Dopa without impairing the effect. The symptom most favorably affected was hypokinesia. They indicated

that tremor and rigor to some extent persist: "A marked tremor," they write,⁴ "was only rarely improved. Rigor tended to diminish in the same way when treatment at high dosage was prolonged, but it did not always disappear completely." Cotzias and colleagues⁵ in their L-Dopa study found that akinesia improved first, followed by rigidity and then tremor.

One major investigator told me that tremor often *increases* in the early phase of L-Dopa treatment. Diurnal variations in the anti-tremor response to L-Dopa were reported by a patient seen by me in a clinical case presentation. This patient had been treated for two years with marked reduction of akinesia and rigidity. He felt that his tremor was worse in the morning on awakening and least marked one or two hours after L-Dopa intake. Webster¹⁶ has reported that, "tremor is the hardest symptom to eliminate. While in some patients, the amplitude is less and the duration of the tremor burst are shorter, most patients revert to tremor characteristics measured five years earlier."

In a study by Fuengeld,⁶ amantidine (average of 300 milligrams daily) was given to 25 patients with Parkinson's disease. Improvement in rigor occurred in 17 patients, tremor improved in 15, and akinesia in 8, within 24 to 48 hours after starting amantidine.

A double-blind, cross-over trial of amantidine (200 milligrams daily and placebo, each given for two weeks) was conducted by Parkes, *et al.*⁷ on 37 outpatients with Parkinson's disease. Thirty-five patients completed the trial and give highly significant preference for amantidine. All pathologic features showed a significant improvement in score on amantidine, except for the patient's assessment of their walking ability and the observers' examination of rigidity. The degree of improvement was not related to age, sex, duration or severity of disease, previous thalamotomy, or concurrent medication. They concluded that although the *amount* of benefit may be less with amantidine than with L-Dopa, amantidine was free of side-effects and

†duPont's tradename for amantidine hydrochloride.

was well tolerated. In a subsequent trial of amantidine by Parkes, *et al.*⁸ doses of 100, 300, and 500 milligrams daily were given for two weeks. Results confirmed the benefit seen with amantidine in previous trials and showed considerable variation in optimum dose; the preferred dose was 300 milligrams daily, which resulted in a 26 per cent reduction in initial disability score. The response at each dose level was greatest in the most disabled patients.

Some patients on combinations of amantidine with the standard synthetic anticholinergic drugs (such as trihexyphenidyl and benztropine) quickly show improvement but later develop mental complications. Researchers, therefore, suggest that dosage of other drugs be lowered when amantidine is also administered. Amantidine can then be continued in full dosage provided the patient is closely watched for signs of central stimulation. Such a synergistic effect is also observed in some patients on combined administration of levodopa with an anticholinergic agent.

In addition to the limited antitremor effect of L-Dopa, some 30 per cent of parkinsonian patients do not benefit from this treatment approach because of primary unresponsivity or the necessity to discontinue the drug because of intolerable side effects.

The availability of amantidine with its more specific antitremor effect, high degree of safety and good tolerance in recommended doses of 200 to 300 milligrams daily, and lesser demands in therapeutic cooperation on patient and physician as compared to L-Dopa therapy seems partly to fill a gap left open. Still, only long-term follow-up will show whether the symptomatic improvement is maintained or not. In the series of Schwab, *et al.*¹ the amantidine benefit lasted three to eight months in 58 per cent. One third of the patients who responded initially showed a slow, steady reduction in benefit after four to eight weeks, not attributable to progressing disease. This reduction in drug efficacy usually leveled off, leaving the patient with moderate

control of symptoms. Five patients who did not respond initially benefited from a second trial of amantidine one to three months later. All eight responsive patients, shifted to placebo, had increased symptoms after two to seven days. All nine patients who changed to levodopa after responding to amantidine responded to levodopa. Two unresponsive patients did not benefit from levodopa. Thus, amantidine might be useful as an indicator of the likelihood of benefit occurring from levodopa and vice versa.

Does simultaneous treatment with L-Dopa and amantidine have a synergistic effect? A preliminary answer is given by Godwin-Austen, *et al.*⁹ A double-blind crossover trial of combined treatment with amantidine and L-Dopa was conducted in 24 patients with parkinsonism. Twelve were on long-term treatment with L-Dopa, and amantidine was added to their treatment, while 12 had L-Dopa added to their long-term treatment with amantidine. Further benefit was shown in the group in whom amantidine treatment was supplemented by L-Dopa, whereas no additional benefit was detected in patients on optimal L-Dopa therapy when amantidine was added. Godwin-Austen, *et al.*⁶ concluded that combined treatment with these drugs is indicated only when the maximum tolerated dose of L-Dopa is very small. Hunter, *et al.*¹⁰ concur with Godwin-Austen and his colleagues' observation that when amantidine is given to patients on optimal L-Dopa therapy, there is no detectable additional benefit. Their patients' opinions on therapy closely matched the disability scores. Twelve of the 13 patients reported benefit from L-Dopa. Of these, five showed a good, six a moderate, and one a slight response. Only one patient noticed a change in supplemental therapy and that was when placebo was substituted for 200 milligrams of amantidine. Other although blind, observations by Vollen¹¹ and Fieschi, *et al.*¹² had suggested that parkinsonian patients on L-Dopa show increased benefit when given amantidine.

Although the induction of therapeutic effects

with amantidine and L-Dopa is impressive, it is still far from satisfactory. But this might be too great an expectation since we are dealing (despite the scarcity of macroscopic and microscopic neuropathological findings) with a slowly degenerative and complex disease process. Only long-term therapeutic studies of patients with early parkinsonism will tell whether the evolution of the parkinsonian process can be halted, whether patients treated at onset of their disease can be cured.

An illuminating and thought-provoking discussion of the etiology of Parkinson's disease has been recently presented by Strang.¹³ He concluded that there is "but one disease—parkinsonism—with a common etiology, protean precipitating factors and possessing an enormously variable onset, course and symptomatology" and "that the illness has little to learn from syphilis in the art of 'mimicry'." He stated that the fundamental disease (parkinsonism) is "primarily determined by nature and severity of the precipitating factors, and the quality and degree of resistance of the inherited substrate material." Strang¹³ considered strain, stress, anxiety, and other emotions as the most common precipitating factors: "success inhibits its development, while frustration, emotional failure, and disturbances and failure will evoke it." "All forms of parkinsonism are hereditary and degenerative, and, genetically, both 'functional' and 'structural' in character. The mode of inheritance is autosomal dominant." Strang¹³ predicts a marked increase in incidence in parkinsonism due to better recognition of atypical forms, and due to the greater stresses and strain of modern life. He considers the current figure of one million parkinsonian patients as already "patently low" and suggests that within the next two decades the disease will be found to have relatively the same relationship to the Asian influenza epidemic, as it is assumed to have to the Spanish pandemics today.

In view of such dire predictions, the introduction of chemicals like L-Dopa and the lesser known amantidine offers a ray of hope

and justifies a judiciously optimistic outlook for future therapy in what seemed to be a rather discouraging field. Strang's study¹³, in addition, would suggest a preventive effect through stress-relieving measures. The effect of surgically induced lesions of the thalamus in lessening both tremor and rigidity in some patients seems to indicate that overaction of the thalamic reflex circuit is an important factor in the parkinsonian type of neuronal instability. The artificiality of the dichotomy between the specialties of psychiatry and neurology seems to become obvious.

A possible explanation for the reported efficacy of amantidine in parkinsonism was suggested by Grelak, *et al.*¹⁴ Amantidine appears to be effecting the release of dopamine and possibly other catecholamines from neuronal storage sites. The agent has shown no anticholinergic activity. Thus, the catecholamine-releasing action of amantidine appears to be its mode of action, which seems to be supported by the electroencephalographic observations of Fuengeld.⁶ The electroencephalogram (which in 16 of his patients showed slow waves and in some way was definitely abnormal) improved considerably within two weeks after starting amantidine, with an increase in fast activity, indicative of a centrally arousing effect. In five patients the EEG completely reverted to normal.

While it is unlikely, it is still interesting (in view of the concept of postencephalitic parkinsonism and possible viral latency) to speculate whether the therapeutic effectiveness of amantidine could be due to its antiviral effect. Amantidine prevents penetration of the virus into the host cell rather than showing any viricidal activity.

While side effects of amantidine treatment are mild the recent observation by Shealy, *et al.*¹⁵ of livedo reticularis in female patients should be mentioned. Ten of 18 women treated with amantidine (100 to 200 milligrams daily during a period of one month or longer) developed livedo reticularis, a red-purple venous marbelizing of the skin, disap-

pearing within four weeks after cessation of amantidine therapy. Livedo reticularis is similar to cutis marmorata, a term used to describe transient reticular discoloration appearing on exposure to cold but disappearing with warming of the limb.

Skilled clinical observation is the only method to date for identifying new drug types. This case study was written to add to the increasing knowledge that some relief can be offered to a large group of patients who until now often progressed inexorably to helplessness, disability, and despair.

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896 Valley Road

Can You Learn While You Sleep?

The University of Florida has reported studies that suggest the possibility of learning while asleep. The project was supported by HEW's National Institute of Mental Health. Doctors Michael Levy and Wilse Webb have demonstrated that sleep learning *can* occur during the deepest stages of slumber as well as during the lighter stages. This ability to learn while sleeping appears to improve with training.

Participating in the studies were students who tried to learn 12 pairs of Russian/English nouns while asleep. None of the subjects had any prior knowledge of Russian. The word pairs had a zero chance of being guessed correctly. In one part of the study, the level of learning approached 30 per cent.

Before the subjects fell asleep, a "conditioning" tape was played. The tape began: "You know that your ability to learn while you are

asleep depends entirely on your willingness to cooperate . . . it will be very easy for you to learn to fall into a very deep sleep and you will learn . . . " Following this, five nights were devoted to actual sleep learning. Before the recording of noun pairs was played, the sleeping subjects heard the words: "This is your Russian teacher . . . you are asleep and relaxed and you can hear my voice, and you will not wake up . . . you will remember these words and their meanings forever . . . "

For some, the average recall (over all nights) for deep-sleep learning was 13 per cent. When training tapes were played while the students were in early light sleep, average retention scores ranged from 10 to 17 per cent. When the subjects heard the training tapes during light sleep late in the night, their scores ranged up to 30 per cent retention. It seemed clear that the ability to learn while asleep improves with training and practice.

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New Narcotic Control Agency

(The following is abstracted from a July 6 release issued by the Washington office of the AMA.)

The Congress has been asked by the Administration to authorize an additional expenditure of \$155 million for the control of drug addiction. In a special message, President Nixon said, "If we cannot destroy the drug menace in America, then it will surely destroy us." The Administration's program would:

Make Veteran's Administration facilities available to all former servicemen in need of drug rehabilitation regardless of the nature of their discharge and provide \$14 million for this program.

Seek \$105 million from Congress to be used solely for treatment and rehabilitation of drug addicts.

Request an additional \$10 million to improve education programs on dangerous drugs.

Request special legislation permitting the government to use information obtained by foreign police and other technical measures to make it easier to prosecute drug pushers.

Ask for an additional \$25.6 million to expand efforts against drug smugglers.

Request \$2 million to expedite research and development of detection equipment and technics.

Request \$2 million for the Agriculture Department to develop herbicides that would destroy narcotics-producing plants.

Request \$1 million for assistance to other nations in training law enforcement officers.

Implicit in the Presidential drug control proposal is the endorsement of methadone in the treatment of veterans addicted to heroin. This high level sanction of the heretofore somewhat controversial and experimental use of methadone marks a turning point in the nation's attempt to rehabilitate addicts. Observers believe the decision to make wide-scale use of methadone was influenced by official recognition of the discouraging low "cure" rate from other approaches to the problem.

Named by the President to head the new drug control program was Jerome H. Jaffe, M.D., a Chicago psychopharmacologist and director of the Illinois State Drug Abuse Program. Dr. Jaffe, an advocate of the methadone treatment method, will serve as a White House consultant until the new agency is organized.

President Nixon has asked the American Medical Association to join in the nationwide war on drug abuse. Mr. Nixon said that there was a link between inappropriate use of drugs within the medical context and the abuse of drugs outside that context. The President pointed out that, "In the last four years alone, the production and distribution of tranquilizers in our country has doubled. During 1970, 5 billion doses of tranquilizers, 3 billion doses of amphetamines, and 5 billion doses of barbiturates were produced in this country. Fifty per cent of the amphetamines and barbiturates were diverted into illegal sales. So there is a problem in the terms of education as well as enforcement. One third of all Americans between the ages of 18 and 74 used a psychotropic drug of some type last year. And little wonder—for there were enough drugs of this type available last year to medicate every adult in the United States at very high dosage rates for more than 11 days. We have produced an environment in which people come naturally to expect that they can take a pill for every problem—that they can find satisfaction and health and happiness in a handful of tablets or a few grains of powder."

The President challenged organized medicine to provide the leadership "this country craves for" in all areas of health care.

"The health of America is in your hands, and by its health I speak not just of its physical health (but) its mental health, its moral health, its character," the President said.

In immediate response to the President's challenge to American Medicine, the AMA's special communications program answered the Chief Executive's call for physician leadership in a full page message that appeared in many of the nation's principal newspapers. The message, titled "We Accept, Mr. President," responded point-by-point to Mr. Nixon's request for broad physician-support in all aspects of the nation's health. In a recent letter to the Bureau of Narcotics and Dangerous Drugs, the AMA has stated that it will do everything possible to assist in implementing a proposed regulation that will curb the abuse of amphetamines and methamphetamines. "Physicians throughout the nation are concerned about the alarming dimensions of the drug abuse problem," wrote Richard S. Wilbur, M.D., AMA's deputy executive vice-president. Pointing out that while the proposed regulation reclassifying amphetamines and methamphetamines as narcotic

substances such as morphine, codeine, and opium would add to the inconvenience of physicians in their practices through additional requirements concerning ordering, record-keeping, and prescribing." Dr. Wilbur assured the Bureau that most physicians were in accord with the proposed regulation.

The AMA letter followed quickly after the House of Delegates meeting in Atlantic City in late June adopted the following resolution:

Resolved, That the American Medical Association urge all physicians to limit their use of amphetamines and other stimulant drugs to specific, well-recognized medical indications, and be it further

Resolved, That the American Medical Association support the proposal of the Bureau of Narcotics and Dangerous Drugs to transfer amphetamine and methamphetamine and their salts, optical isomers, and salts of their optical isomers from Schedule III to Schedule II published in the May 26, 1971 Federal Register.

Learning About Depression

Depression is becoming one of the major medical problems today. Perhaps, things being what they are, depression is only natural. Recently developed is a "depression learning system," an intensive educational project for all M.D.'s. It is a three-part system:

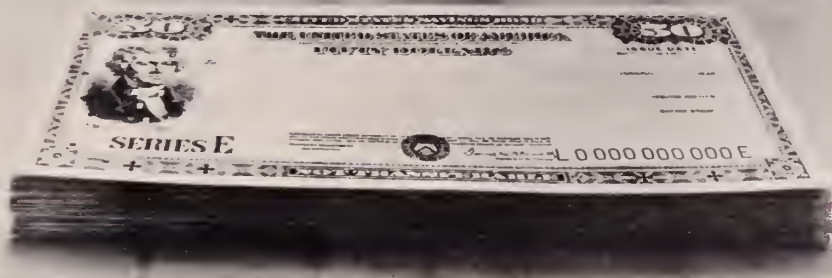
1. A full-color documentary film of 30-minutes' duration—educational and stimulating. This new medical film explores this subject with up-to-date information. From Sir Denis Hill in London, Dr. Leo Hollister in Palo Alto, Dr. Joseph Schildkraut in Boston, and many more, you will see and hear the experiences of successful practitioners.
2. A comprehensive monograph. This practical document provides insight into the clinical implications of depression.
3. A self-evaluation section. Assurance that

the knowledge gained is knowledge retained is the purpose of this innovative section. Essential questions and their correct answers are provided so that the physician can test himself for his new knowledge of depression.

Here is a unique three-part learning system that not only explains the symptoms and causes of depression, but also treatment of choice, and when to use antidepressant drugs, electroconvulsive therapy, psychotherapy, or when to hospitalize.

This project in continuing physician education is provided as a service to the profession by Lakeside Laboratories of Milwaukee. Want to participate in this unique learning experience? Write to Professional Services Department, Lakeside Laboratories, 1707 East North Avenue, Milwaukee, Wisconsin 53201.

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Facts about Loridine® I.M. cephaloridine

Facts about activity

Loridine is indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed below.* It is active against the following organisms in vitro:

Beta-hemolytic and other streptococci (many strains of

enterococci, e.g., *Streptococcus faecalis*, are relatively resistant)

Staphylococci, both coagulase-positive and coagulase-negative (some strains of staphylococci are resistant to cephaloridine)

Pneumococci

Gonococci

Hemophilus influenzae

Escherichia coli and other coliform bacteria

Klebsiella

Proteus mirabilis

Loridine also has demonstrated activity against *Treponema pallidum* in experimental syphilis studies in animals.

All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine. However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *H. influenzae*, *Pr. mirabilis*, *Esch. coli*, and *Klebsiella* are also susceptible in vitro.

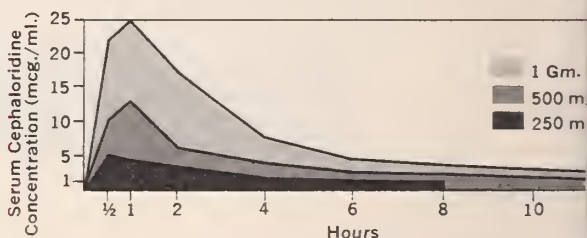
Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

*Loridine is indicated in the treatment of gonorrhea when penicillin is not considered the drug of choice.



Facts about dosage

In adults, most respiratory infections of moderate severity caused by susceptible organisms respond to Loridine in dosages ranging from 500 mg. to 1 Gm. every eight hours (1.5 to 3 Gm. daily). This use of lower dosages helps prevent drug accumulation. The more susceptible infections have been treated with 250 to 500 mg. every eight hours.



Mean Serum Cephaloridine Concentrations after I.M. Administration of Single Doses (250 mg. to 1 Gm.) to Normal Human Volunteers (Sixteen Subjects per Group). (Modified from Currie, J. P.: Cephaloridine: Pharmacology and Toxicology, Postgrad. M. J., 43 [Supplement 22, 1967].)

Peak serum levels have been noted with Loridine within one-half to one hour following I.M. injection. The mean peak serum levels obtained in normal subjects one hour after a 500-mg. I.M. dose ranged from 12 to 22 mcg. per ml. in separate studies. Administration every six to eight hours permits adequate concentrations to be maintained. In order to avoid excessive serum levels (which could possibly result in damage to the kidney tubules), recommended dosages should not be exceeded. In adult patients without azotemia who have mildly reduced renal function manifested by slight to moderate transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the maximum recommended dosage is 1 Gm. every twelve hours during the period of reduced function.

acts about administration

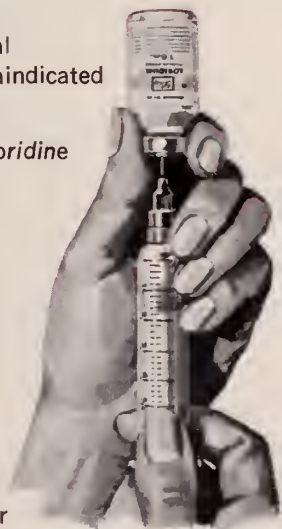
the following guidelines for therapy with Loridine are recommended.

Before Administration of Loridine

Establish susceptibility of the pathogen.
Determine patient's renal status; Loridine is contraindicated in azotemia.

During Administration of Loridine

Maintain proper hydration.
Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
Use cautiously with other potentially nephrotoxic drugs.
Because nephrotoxicity has been reported, limit dosage to 4 Gm. daily for adults (100 mg. per Kg. for children—not to exceed adult dosage).
Usual dosage range: 1 to 3 Gm. daily.



5. In patients with impaired renal function *before* treatment, reduce daily dosage and keep them under close observation for changes in function. In nonazotemic patients with mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage (adults) is 1 Gm. every twelve hours during the period of reduced function.
6. In patients who develop impaired renal function or whose preexisting impairment becomes worse *during* treatment, discontinue therapy.

Since Loridine is relatively painless on I.M. injection, it is well accepted by patients.

There is clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins; therefore, Loridine should be used with great caution in patients with known penicillin allergy. Instances of patients who have had severe reactions to both drugs, including death from anaphylaxis, have been reported.

Loridine[®] I.M.
cephaloridine



101666

(Please turn page for prescribing information.)

Loridine® I.M.

cephaloridine

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred

in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Phlebitis in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important. Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended in the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reaction. For this reason, Keflin® (sodium cephradine, Lilly) may be preferred when dosages larger than 4 Gm. daily are considered in life-threatening situations. If more than 4 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 60 mg. per Kg. (15 to 25 mg. per pound) body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size; rubber-stoppered; 1 Gm., 10-ml. size; rubber-stoppered.



101666

Additional information available to the profession on request.

Eli Lilly and Company
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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

July 18, 1971

A regular meeting of the Board of Trustees was held on July 18, 1971, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Conference of Presidents . . . Approved a request to schedule the Fall Conference of Presidents and Presidents-Elect of Component Societies in conjunction with the October 17th meeting of the Board.

SMJAB Conference . . . Authorized the Assistant Editor and the Advertising Manager to attend (with specified expenses paid) the SMJAB Conference in New Orleans, September 13 and 14.

Proposed Rule Pertaining to Minimum Eye Examination . . . Received notification (under date of June 15, 1971) from the State Board of Medical Examiners that it has disapproved the proposed rule pertaining to minimum eye examination (see page Tr 122, *July Journal*), and has instructed the President of the Board to appoint a committee to meet with representatives of MSNJ and the Academy of Ophthalmology and Otolaryngology in an effort to reach a satisfactory solution.

Testimonial for Mr. Sooy . . . Authorized the Chairman of the Board of Trustees to attend a testimonial dinner in honor of Ellsworth Sooy, Director of Sales at Chalfonte-Haddon Hall, who will retire on August 1st after 45 years of service to the hotel. MSNJ will present a citation to Mr. Sooy.

New Jersey Chapter, American College of Emergency Physicians . . . Agreed to add the

local chapter of the American College of Emergency Physicians (organized on June 22, 1971) to its list of official intermediaries with specialty societies, and directed that the organization be called to the attention of the Annual Meeting Committee.

Congress on Occupational Health . . . Authorized the Chairman of MSNJ's Committee on Occupational Health, Workmen's Compensation, and Rehabilitation to attend (with expenses paid) the Annual Congress on Occupational Health, Grand Teton National Park, Wyoming, August 29 and 30.

Conference of State Mental Health Representatives . . . Authorized the Chairman of MSNJ's Council on Mental Health to attend (with expenses paid) the Annual Conference of State Mental Health Representatives, Chicago, September 24 and 25.

Conference on Physicians and Schools . . . Authorized the Chairman of MSNJ's Committee on Child Health to attend (with expenses paid) the National Conference on Physicians and Schools, Chicago, September 30 to October 2.

Annual Meeting Committee . . . Approved the report of the July 11 meeting of the Committee on Annual Meeting, including the following recommendations:

1. That \$2.50 of the annual per capita assessment be earmarked for the annual meeting expenses.
2. That letters be sent to Presidents, Secretaries, and Executive Secretaries of Component Societies specifically drawing attention to the change in annual meeting dates (see page Tr 35, *July Journal*, and pages 668 and 669, *August Journal*).

Note: The changes in dates will necessitate moving up deadlines for receipt of annual reports, resolutions, names of delegates and alternates, etc., as well as advancing the mailing dates of annual meeting materials.

3. That items directing attention to the changes in annual meeting dates be carried in each issue of

The Journal and the *Membership-Newsletter*, and that the subject be placed on the agenda for the meeting of component society presidents.

Medical Education . . . Approved as amended the report of the June 13 meeting of the Committee on Medical Education, including the following recommendations:

1. *National Intern and Resident Matching Program*

The Committee on Medical Education recommends the National Intern and Resident Matching Program with the understanding that all New Jersey hospitals (should) participate in it so that there will be no unfair advantage for hospitals that remain non-participating. (The Board amended the recommendation by deleting the word "should.")

2. *Resolution #14—"Development of More Family Physicians"*

That Dr. Rogers should call on the deans of the two medical colleges and personally present a letter, including Resolution #14, which would indicate to the deans that the Committee is eager to cooperate with the medical schools in the implementation of this resolution. It should also be brought to their attention that the deadline to admit and graduate at least 200 students a year by 1975 although desirable is obviously impracticable.

3. *Resolution #19—"Reducing Duration of M.D. Curriculum"*

That the same procedure be followed as for Resolution #14, but it (Committee on Medical Education) requested that Dr. Rogers point out to the deans of the two medical colleges that the Committee advocates the medical college curriculum's being concentrated in three calendar years but only to the extent consonant with the preservation of essential content and quality.

4. *Accreditation of Programs of Continuing Physician Education in New Jersey*

That until such a committee (for inspection and accreditation on a statewide basis) be viable and functional, hospitals continue to apply to the AMA for inspection and accreditation.

AMA Convention (1971) . . . Approved the following report of the New Jersey Delegation to the 1971 AMA Convention.

The 120th Annual Convention of the American Medical Association was held in Atlantic City from Sunday, 20 June through Thursday, 24 June. The total registration for the convention was 22,906, about two thousand higher than the total attained in Chicago in 1970. There were 8,216 M.D.'s registered in Atlantic City.

The Medical Society of New Jersey was represented in the House of Delegates by its seven elected delegates: Doctor Joseph P. Donnelly, Delegation Chairman; Doctor Frank J. Hughes, Doctor Jerome G. Kaufman, Doctor John F. Kustrup, Doctor Jesse McCall, Doctor Luke A. Mulligan, and Doctor Isaac N. Patterson.

All seven alternate delegates attended: Doctors Louis F. Albright, John J. Bedrick, George L. Benz, Nicholas A. Bertha, Joseph R. Jehl, Emanuel M. Satulsky, and Robert E. Verdon. Also present as official representatives of MSNJ and in attendance at the sessions of the House of Delegates and its reference committees were Doctor E. Vernon Davis, President; Doctor William J. D'Elia, President-Elect; and Richard I. Nevin, Executive Director. Doctor Kustrup was a member of the Committee on Credentials and Doctor Mulligan served on Reference Committee "D." Doctor James A. Rogers, Second Vice-President, was present at the convention and offered his services to the delegation.

At the opening session on Sunday afternoon, Doctor McCall read to the House a memorial resolution offered by The Medical Society of New Jersey in honor of David Bacharach Allman, M.D. The House stood in silent prayer in tribute to the former President of the AMA.

The New Jersey Delegation was successfully active in another matter that must certainly be related also to Doctor Allman. It won final approval of the House of Delegates for Atlantic City as the site of the Annual Convention in 1975. Tentative approval had been granted at the Clinical Convention in Boston last winter, subject to the 1971 experience at Atlantic City.

New Jersey introduced Resolution #63, in conformity with the directive given by our House of Delegates last May. It called upon the AMA to request the Joint Commission on Accreditation of Hospitals "to increase the emphasis on plant and equipment status of an institution undergoing an approval survey." Resolution #63 was adopted, on recommendation of Reference Committee "D," which reported: "Testimony indicated that to a large degree the intent of Resolution #63 will be achieved. The Joint Commission in implementing its revised standards, effective July 1, 1971, will place increasing emphasis on hospital plant and equipment."

Again, in furtherance of the indicated wishes of MSNJ's House of Delegates, the New Jersey Delegation supported those resolutions before the AMA House opposing the recent FDA regulation against combination drugs, particularly Resolution #12, introduced by the Nevada Delegation, and Resolution #14, introduced by the Connecticut Delegation. Reference Committee "E" offered, and the House adopted, the following resolution as a substitute for Resolutions 12, 14, 45, and 87:

"Resolved: that the American Medical Association recommend that any Congressional Committee authorized to investigate or act upon matters relating to the operation and activities of the Food and Drug Administration include within such investigation and consideration the question of the FDA's basing regulatory action on controversial scientific studies."

The AMA House received a statement, submitted by the Council on Medical Education, modifying *AMA policy regarding eligibility of foreign medical graduates for appointment to approved internships and residencies*. Properly qualified students who study medicine at a medical school outside the United States, Puerto Rico, and Canada, but which is recognized by the World Health Organization, and who have completed all formal requirements of the foreign school except internship and/or social service, may hereafter substitute for an internship required by

the foreign medical school, "an academic year of supervised clinical training (such as a clinical clerkship or junior internship) prior to entrance into the first year of AMA approved graduate medical education." Such supervised clinical training must be under the direction of a medical school approved by the Liaison Committee on Medical Education.

Before beginning the supervised clinical training, said students must have their academic records reviewed and approved by the medical schools supervising their clinical training and must pass a screening examination acceptable to the Council on Medical Education, such as Part I of the National Board examinations, or the ECFMG examination, or the FLEX examination.

Said students who are judged by the sponsoring medical school to have completed successfully the supervised clinical training are eligible to enter the first year of AMA-approved graduate training programs without completing social service obligations required by the foreign country or obtaining ECFMG certification.

The Council on Medical Education will recommend to all state boards of medical examiners that they consider for licensure all candidates who have completed successfully the supervised clinical training on the same basis as they now consider foreign medical candidates who have received ECFMG certification.

Assignments for coverage of the reference committees of the House, which met on Monday, 21 June, were as follows: Amendments to the Constitution and By-laws . . . Doctor Patterson; Reference Committee "A" . . . Doctors Kustrup and Albright; Reference Committee "B" . . . Doctors McCall and Bertha; Reference Committee "C" . . . Doctors Donnelly, Satulsky, and Rogers; Reference Committee "D" . . . Doctor Hughes (Doctor Mulligan served as a member of this Reference Committee); Reference Committee "E" . . . Doctors Davis and Jehl; Reference Committee "F" . . . Doctors Kaufman and D'Elia; Reference Committee "G" . . . Doctors Bedrick and Benz; Reference Committee "H" . . . Doctor Verdon.

We held our usual, frequent caucuses and also interviewed the candidates for the offices to be filled by election. This year, with the cooperation and support of the Atlantic City Convention Bureau our Society ran an active and successful hospitality suite. We spent considerable time in trying to win the delegates to support confirmation of Atlantic City as the site for the AMA Annual Convention in 1975. The Convention Bureau and its Director, Mr. Wayne Stetson, Mayor Sommers, and the various representatives of the Atlantic City administration and business interests were helpful in waging what proved to be a successful campaign to bring the convention to Atlantic City in 1975.

All the members of our delegation and their wives were invited to be the guests of the Atlantic City Convention Bureau on Friday evening at a pre-convention dinner with members of the AMA Board of Trustees and their wives, held at the Smithville Inn. The Bureau presented Lenox salt and pepper sets to the lady dinner guests.

As features of the campaign of persuasion, delegates and alternates to the Convention were entitled to a chance on a Boehm Bird, won by Blair J. Henningsgaard, M.D. of Oregon. In the name of The Medical Society of New Jersey flower arrangements

were sent to the delegates' rooms. This feature was well received and was the subject of many expressions of appreciation. Boxes of candy were distributed to the visitors to the New Jersey Hospitality Suite. The foregoing was made possible by the Convention Bureau.

A summary report of the significant actions of the House of Delegates was contained in the July MSNJ *Membership Newsletter*. A complete digest of the action of the House of Delegates will be published by the AMA.

Woman's Auxiliary . . . Approved, on recommendation of the Advisory Committee to the Woman's Auxiliary, the Auxiliary program for 1971-1972, which is essentially the same as that of 1970-1971.

Special/Liaison Committees and/or Representatives . . . Approved the proposed list of special and liaison representatives and special committees for 1971-1972 (see page 772, this issue).

Peer Review Committee—Resolution #16 . . . Directed that the Special Committee on Long Range Planning and Development call a meeting of interested councils and committees (Judicial Council, Council on Medical Services, and Committee on Medical Education) to discuss peer review and report the results to the Board within four months.

Professional Liability Insurance Program . . . Directed that a letter, through the Joseph A. Britton Agency, be sent to Chubb and Son, Inc., indicating the Society's acceptance of the proposals submitted for writing a liability insurance program for MSNJ.

Academy of Medicine Library . . . Noted that the Library of the Academy of Medicine of New Jersey will be taken over by and moved to the College of Medicine and Dentistry of New Jersey at Newark. The library will continue to be available to members of the Academy which has committed \$5,000 to the school for the next five years to underwrite the cost of service to its members.

Vacancy on Committee on Medical Education . . . Appointed John R. Wolgamot, M.D. of Moorestown (until the 1972 Annual Meet-

ing) to fill the vacancy on the Committee on Medical Education resulting from the resignation of John W. Nicholson, III, M.D.

Utilization Review . . . Voted to refer a request from the New Jersey Hospital Association for a joint *ad hoc* task force to explore the need for improving utilization review and the possible demand by the State for information on quality of care being rendered in hospitals to the Special Committee on Long Range Planning and Development.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during July 1971:

	1971 July	1970 July
Aseptic Meningitis	10	2
Primary Encephalitis	3	
Hepatitis: Total	405	323
Infectious	309	240
Serum	96	83
Malaria: Total	8	10
Military	6	7
Civilian	2	3
Meningococcal Meningitis	4	10
Mumps	76	117
German measles	11	34
Measles	61	51
Salmonella	171	58
Shigella	25	24

Pesticide Poisonings

The New Jersey Community Study on Pesticides is involved in a review of the long-term and short-term effects of pesticide exposure on the health of the general population and the occupationally exposed. As an ancillary facet of this program, we are able to offer assistance in cases of human poisonings by pesticides.

The present trend toward a decline in the use of the more persistent organochlorine pesticides, such as DDT, will result in a

corresponding increase in the use of the more toxic and less persistent organophosphates, such as parathion. The organophosphates include some of the most dangerous chemicals known to man. An increased number of poisonings can be expected with the anticipated rise in their usage.

To prepare for a possible upsurge of pesticide poisonings, the Pesticide Project is interested in fostering a high index of suspicion for such poisonings by the medical community. With this in mind, we would appreciate receiving reports of actual or suspected pesticide poisonings. Telephone the Pesticide Project (609-292-7608). After hours and on week-ends, call 609-392-2020. Information on previous poisonings, if known, would also be appreciated.

Reprints are available of a paper by Donald S. Kwalick, M.D., "Physicians' Pesticide Primer," which appeared in *The Journal of The Medical Society of New Jersey*, May 1971. Requests should be addressed to the Pesticide Project, New Jersey Department of Health, P.O. Box 1540, Trenton, New Jersey 08625.

Trichinosis

Trichinosis increased in New Jersey during 1971. Twelve confirmed cases were reported for the first seven months. During 1970 there were twelve cases. Annual average for the past five years was eight cases. Two family outbreaks account for eight cases this year with four persons becoming ill in each family. The remaining four were single cases.

Diagnosis of trichinosis is based on a combination of clinical symptoms, physical signs, skin and serological tests, and muscle biopsy. Eosinophilia is the most common laboratory finding and periorbital edema, the most common sign. Other clinical findings include myalgia, diarrhea, malaise, fever, chills, and conjunctivitis. The Bentonite-Flocculation test performed by the State laboratory is also a reliable indicator of infection.



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helps overpower pain

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Op. 3 contains codeine phosphate* (32.4 mg.) gr. ½.

Op. 4 contains codeine phosphate* (64.8 mg.) gr. 1.

(Warning—may be habit forming.)

Empirin Compound with Codeine is now classified in Schedule III.
Available on oral prescription and may be refilled 5 times
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1971-1972

Committees and Councils

STANDING COMMITTEES

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 Arthur Bernstein, M.D., *Vice-Chairman* (1972) Maplewood
 Nicholas A. Bertha, M.D. (1973) Wharton
 Donald C. Davidson, M.D. (1973) Atlantic City
 John J. Thompson, M.D., (1974) Caldwell
 Robert E. Verdon, M.D. (1972) Cliffside Park
 Louis F. Albright, M.D., *Secretary*
 Ex-Officio Spring Lake

Scientific Exhibits

Arthur Bernstein, M.D., *Chairman* Maplewood
 H. Irving Dunn, M.D. Bay Head
 George L. Erdman, M.D. Summit
 Arthur Krosnick, M.D. Trenton
 John J. Thompson, M.D. Caldwell

Scientific Program (Sections)

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 Arthur Forst, M.D., *Secretary* North Caldwell

Anesthesiology

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 H. A. Ferrari, M.D., *Secretary* Summit

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Chest Diseases

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Ralph M. L. Buchanan, M.D., *Chairman*
 (1973) Phillipsburg
 Charles H. Calvin, M.D., *Vice-Chairman*
 (1972) Edison
 Elton W. Lance, M.D. (1974) Rahway

Medical Defense and Insurance

William J. D'Elia, M.D., *Chairman*
 (1973) Neptune City
 Paul J. Kreutz, M.D., *Vice-Chairman*
 (1972) Elizabeth
 Irving P. Borsher, M.D. (1974) Newark

William G. Kuhn, Jr., M.D. (1973) . . . New Brunswick
 William L. Palazzo, M.D. (1972) . . . Teaneck
 Jesse Schulman, M.D. (1974) . . . Lakewood
 Louis F. Albright, M.D., *Secretary*,
 Ex-Officio . . . Spring Lake
 Ernest C. Hillman, Jr., M.D., *Consultant* . . . Glen Ridge
 Benjamin F. Slobodien, M.D.,
Consultant . . . Perth Amboy

Medical Education

James A. Rogers, M.D., *Chairman* (1973) . . . Paterson
 John A. Kinczel, M.D., *Vice-Chairman*
 (1974) . . . Trenton
 Arthur Bernstein, M.D. (1974) . . . Maplewood
 William T. Snagg, M.D. (1972) . . . Camden
 Edward H. Weiser, M.D. (1972) . . . Sussex
 John R. Wolgamot, M.D. (1972) . . . Moorestown
 Edward A. Wolfson, M.D., *Consultant* . . . Glen Rock

Medical Student Loan Fund

William Greifinger, M.D., *Chairman*
 (1972) . . . Belleville
 Charles H. Calvin, M.D., *Vice Chairman*
 (1973) . . . Edison
 Charles Cunningham, M.D. (1973) . . . Vineland
 Joseph R. Jehl, M.D. (1974) . . . Clifton
 William R. Muir, M.D. (1974) . . . Mount Holly

Publication

George B. Sharbaugh, M.D., *Chairman*
 (1972) . . . Trenton
 Daniel B. Roth, M.D., *Vice Chairman*
 (1973) . . . Teaneck
 Arthur Krosnick, M.D. (1974) . . . Trenton
 William J. D'Elia, M.D., *President-Elect*,
 Ex-Officio . . . Neptune City
 Louis F. Albright, M.D., *Secretary*,
 Ex-Officio . . . Spring Lake
 Henry A. Davidson, M.D., *Editor*,
 Ex-Officio . . . East Orange

Revision of Constitution and Bylaws

William R. Muir, M.D., *Chairman*
 (1974) . . . Mount Holly
 Fred A. Mettler, M.D., *Vice-Chairman*
 (1972) . . . Blairstown
 Meyer L. Abrams, M.D. (1974) . . . Willingboro
 Richard Berlin, M.D. (1973) . . . Teaneck
 Jesse Carll, IV, M.D. (1973) . . . Bridgeton
 John A. Smith, M.D. (1972) . . . South River
 Louis F. Albright, M.D., *Secretary*,
 Ex-Officio . . . Spring Lake
 Joseph M. Gannon, M.D., *Consultant* . . . Plainfield

Woman's Auxiliary

William J. Roe, M.D., *Chairman* (1972) . . . Englewood
 Charles Gandek, M.D., *Vice Chairman*
 (1972) . . . Edison
 Edward M. Coe, M.D., (1973) . . . Cranford
 Frederick W. Durham, M.D. (1974) . . . Haddonfield
 Jesse T. Glazier, M.D. (1973) . . . Newark
 Paul Harrison, M.D. (1974) . . . Mount Holly

ADMINISTRATIVE COUNCILS

Legislation

Jesse McCall, M.D., *Chairman* (1972) . . . Newton
 Henry J. Mineur, M.D., *Vice-Chairman*
 (1972) . . . Cranford
 Meyer L. Abrams, M.D. (1974) . . . Willingboro
 A. Guy Campo, M.D. (1973) . . . Westville
 John J. Crosby, Jr., M.D. (1973) . . . Jersey City
 John D. Franzoni, M.D. (1973) . . . Trenton
 Leon A. Fraser, M.D. (1973) . . . Trenton

Winton H. Johnson, M.D. (1972) . . . Hackensack
 John S. Madara, M.D. (1972) . . . Salem
 Daniel O'Regan, M.D. (1974) . . . Jersey City
 Francis A. Pflum, M.D. (1974) . . . Asbury Park
 John R. Tobey, M.D. (1974) . . . Newark
 E. Powers Mincher, *Legislative Analyst* . . . Pennington

Medical Services

Louis K. Collins, M.D., *Chairman* (1974) . . . Glassboro
 Frank M. Galieto, M.D., *Vice Chairman*
 (1972) . . . Bloomfield
 Donald T. Akey, M.D. (1974) . . . Metuchen
 David R. Brewer, Jr., M.D. (1972) . . . Woodbury
 Arthur C. Dietrick, M.D. (1972) . . . Mount Holly
 William A. Dwver, Jr., M.D. (1973) . . . Paterson
 David Flinker, M.D. (1972) . . . Moorestown
 Karl T. Franzoni, M.D. (1973) . . . Trenton
 Robert E. Fullilove, Jr., M.D. (1973) . . . Newark
 Robert S. Gamon, Jr., M.D. (1974) . . . Cherry Hill
 Joseph A. Lepree, M.D. (1974) . . . Elizabeth
 James S. Todd, M.D. (1973) . . . Ridgewood
 William J. D'Elia, M.D., *President-Elect*
 Ex-Officio . . . Neptune City
 Nicholas E. Marchione, M.D., *Consultant* . . . Vineland

Mental Health

Robert S. Garber, M.D., *Chairman*
 (1972) . . . Belle Mead
 Edward A. Schauer, M.D., *Vice-Chairman*
 (1973) . . . Farmingdale
 Miles E. Drake, M.D. (1973) . . . Vineland
 Morton Hoffman, M.D. (1974) . . . Mount Holly
 Evelyn P. Ivey, M.D. (1972) . . . Farmingdale
 Clarence W. Jaggard, M.D. (1972) . . . Woodbury
 Arnold Kallen, M.D. (1974) . . . Livingston
 Seymour F. Kuvin, M.D. (1973) . . . Livingston
 J. Lloyd Morrow, M.D. (1974) . . . Passaic
 Eugene V. Resnick, M.D. (1974) . . . Paramus
 John R. Rushton, III, M.D. (1973) . . . Camden
 Martin H. Weinberg, M.D. (1972) . . . Trenton
 Emanuel M. Satulsky, M.D., *Immediate*
Past-President, Ex-Officio . . . Elizabeth

Public Health

Robert G. Salasin, M.D., *Chairman*
 (1972) . . . North Wildwood
 Kendrick P. Lance, M.D., *Vice-Chairman*
 (1973) . . . Paterson
 Roslyn Barbash, M.D. (1973) . . . Teaneck
 William M. Chase, M.D. (1973) . . . East Orange
 Anthony P. DeSpirito, M.D. (1972) . . . Neptune City
 Henry L. Drezner, M.D. (1974) . . . Trenton
 George L. Erdman, M.D. (1974) . . . Summit
 Rudolph G. Matflerd, M.D. (1974) . . . New Brunswick
 Thomas F. McLaughlin, M.D. (1973) . . . Metuchen
 John J. Pastore, M.D. (1972) . . . Vineland
 Francis E. Reiman, M.D. (1972) . . . Jersey City
 Frederick C. Steller, M.D. (1974) . . . Spring Lake
 Matthew E. Boylan, M.D., *First Vice-President*
 Ex-Officio . . . Jersey City
 James R. Cowan, Sr., M.D., *Consultant* . . . Trenton
 Martin Goldfield, M.D., *Consultant* . . . Trenton

Public Relations

John J. Crosby, Jr., M.D., *Chairman*
 (1972) . . . Jersey City
 John P. Kengeter, M.D., *Vice-Chairman*
 (1974) . . . Toms River
 Frank R. Begen, M.D. (1972) . . . Teaneck
 William N. Evans, M.D. (1973) . . . Mount Holly
 Robert Holman, M.D. (1972) . . . Pompton Plains
 Josiah C. McCracken, Jr., M.D. (1972) . . . Ventnor
 John J. McGuire, M.D. (1973) . . . Newark
 John A. Sakson, M.D. (1974) . . . Yardley, Pa.
 Howard D. Slobodien, M.D. (1973) . . . Perth Amboy
 Irwin Smith, M.D. (1974) . . . Willingboro

Ford C. Spangler, M.D. (1973) Salem
 Frank Y. Watson, M.D. (1974) Montclair
 James A. Rogers, M.D., 2nd Vice-President
 Ex-Officio Paterson

SPECIAL COMMITTEE TO THE COUNCIL ON MEDICAL SERVICES

Occupational Health, Workmen's Compensation and Rehabilitation

Delma W. Caldwell, M.D., *Chairman* Linden
 Joshua N. Zimskind, M.D., *Vice-Chairman* Trenton
 James F. Collier, M.D. Haddonfield
 Elmer J. Elias, M.D. Trenton
 John W. Holdcraft, M.D. Woodbury
 Dominic A. Kujda, M.D. Butler
 Carl A. Maxwell, M.D. Phillipsburg
 William D. Van Riper, M.D. New Brunswick
 Mathilda R. Vaschak, M.D. New Brunswick
 Nelson C. Walker, M.D. Hackensack
 Ralph A. Young, M.D. Linden
 Jarvis Smith, M.D., *Consultant* Trenton

SPECIAL COMMITTEES TO THE COUNCIL ON MENTAL HEALTH

Alcoholism

George Rogers, M.D., *Chairman* Camden
 Robert Albahary, M.D. New Brunswick
 David Canavan, M.D. Oakland
 Joseph P. Greeley, M.D. Westfield
 Allen A. Parry, M.D. Madison

Drug Abuse

Henry A. Davidson, M.D., *Chairman* East Orange
 Mary Ann Bartusis, M.D. Trenton
 Hans W. Freymuth, M.D. Trenton
 Granville Jones, M.D. Summit
 Harry Le Fever, M.D. Cherry Hill
 Edward A. Wolfson, M.D. Glen Rock

Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., *Chairman* Paramus
 Jay W. Fidler, M.D. Plainfield
 Harvey Hammer, M.D. Morristown
 Bradford Judd, M.D. Shrewsbury
 Joseph J. Kline, M.D. Trenton
 Alan Kulick, M.D. Millville

Mental Retardation

Miles E. Drake, M.D., *Chairman* Vineland
 Eugene Revitch, M. D. Plainfield
 Catherine Spears, M.D. Chatham
 Robert A. Weinstein, M.D. Newton
 Harry Yolken, M.D. Paterson

Neurological and Related Disorders

J. Lloyd Morrow, M.D., *Chairman* Passaic
 Richard A. Nelson, M.D. Neptune City
 Josiah J. Pegues, M.D. Mount Holly
 Ira S. Ross, M.D. South Orange
 Walter Scheuerman, M.D. Trenton

SPECIAL COMMITTEES TO THE COUNCIL ON PUBLIC HEALTH

Cancer Control

Roy T. Forsberg, M.D., *Chairman* Westfield
 Harold L. Colburn, Jr., M.D. Mount Holly
 Sherman Garrison, M.D. Bridgeton

John A. Ianacone, M.D. Paterson
 Warren H. Knauer, M.D. Hillside
 Bernard Koven, M.D. Englewood
 Charles S. Krueger, M.D. Mount Holly

Child Health

William J. Farley, M.D., *Chairman* Nutley
 Robert E. Jennings, M.D. South Orange
 Glenn P. Lambert, M.D. Flemington
 Thomas P. McFarland, Jr., M.D. Mays Landing
 Bernard N. Millner, M.D. Trenton
 Milton Prystowsky, M.D. Nutley
 Robert D. Rento, M.D. Clifton
 William L. Rumsey, Jr., M.D. Elizabeth
 Sidney Tucker, M.D. Perth Amboy

Conservation of Vision, Hearing, and Speech

Frank B. Vanderbeek, M.D., *Chairman* Paterson
 Bernard A. Balsis, M.D. Trenton
 Alfonse A. Cinottii, M.D. Jersey City
 Ralph L. Dicker, M.D. Dover
 Samuel Diskan, M.D. Atlantic City
 Joseph H. Kler, M.D. New Brunswick
 Oram R. Kline, Jr., M.D. Camden
 Rowan C. Pearce, Jr., M.D. Haddonfield
 Walter A. Petryshyn, M.D. Upper Montclair
 Ralph E. Siegel, M.D. Perth Amboy
 Ralph A. Skowron, M.D. Cherry Hill
 Aris M. Sophocles, M.D. Trenton
 Robert Stern, M.D. Mount Holly
 D. Blair Sulouff, M.D. Morristown
 Anthony M. Sellitto, M.D., *Consultant* South Orange

Environmental Health

Roslyn Barbash, M.D., *Chairman* Teaneck
 Rudolph T. DePersia, M.D. Gibbstown
 Mary B. Hall, M.D. Trenton
 Richard H. Musgnug, M.D. Haddonfield
 E. Spencer Paisley, M.D. Haddon Heights
 Frank L. Rosen, M.D. Maplewood
 William I. Weiss, M.D. Livingston
 Meyer T. Weissman, M.D. Elizabeth

Maternal and Infant Welfare

John D. Preece, M.D., *Chairman* Trenton
 Edward N. Comando, M.D. Millburn
 Robert A. Cosgrove, M.D. Jersey City
 Edward Foord, M.D. Burlington
 Charles D. Foster, III, M.D. Pitman
 John D. Franzoni, M.D. Trenton
 Calvin Hahn, M.D. Vineland
 Herbert F. Johnson, M.D. Camden
 Daniel B. Roth, M.D. Teaneck
 Harold Schwartz, M.D. Millburn
 Jack E. Shangold, M.D. Perth Amboy
 Leopold E. Thron, M.D. Paterson
 Bernard N. Millner, M.D., *Consultant* Trenton

SPECIAL COMMITTEES

Emergency Medical Care

Jack R. Karel, M.D., *Chairman* Hillside
 R. Winfield Betts, M.D., *Vice-Chairman* Medford
 Clifford B. Blasi, M.D. Jersey City
 Charles Campbell, M.D. Hackensack
 Frank Dresdale, M.D. Plainfield
 John A. Flood, Jr., M.D. Trenton
 Dorson S. Mills, M.D. Elmer
 Frank R. Schell, M.D. Butler
 Marie A. Sena, M.D., *Consultant* Toms River

Medicine and Religion

Luke A. Mulligan, M.D., *Chairman* Leonia
 John J. Bedrick, M.D. Bayonne
 Charles H. Calvin, M.D. Edison

John S. Madara, M.D. Salem
 Thomas H. McGlade, M.D. Camden
 Watson E. Neiman, M.D. Cinnaminson

Project Hope and Vietnam

Thomas C. DeCecio, M.D., *Chairman* ... Cliffside Park
 Harold L. Colburn, Jr., M.D. Moorestown
 J. Leonard Greif, M.D. Dover

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., *Chairman* ... Vineland
 Albert F. Moriconi, M.D. Trenton

1971-1972 SPECIAL COMMITTEES SPECIAL/LIAISON REPRESENTATIVES

Academy of Medicine of New Jersey

- (1) Board of Trustees/Liaison Committee
 (Liaison requested by Academy—6/19/66)
 A. Guy Campo, M.D. Westville
 James A. Rogers, M.D. Paterson
 Emanuel M. Satulsky, M.D. Elizabeth
- (2) Post-Graduate Medical Education Study Committee
 (Representative requested by Academy—11/15/64)
 James A. Rogers, M.D., *Chairman*,
Committee on Medical Education ... Paterson
 John A. Kinzel, M.D., *Vice-Chairman*,
Committee on Medical Education ... Trenton

American Medical Association-Education Research Foundation

(Liaison requested by AMA—10/7/51)
 William Greifinger, M.D., *Chairman, Committee on*
Medical Student Loan Fund ... Belleville

Audit Review Committee (1970-71 Audit)

(Appointed annually by Board to review previous
 year's audit)
 Louis F. Albright, M.D., *Chairman* ... Spring Lake
 Edward G. Bourns, M.D. Westfield
 Matthew E. Boylan, M.D. Jersey City
 William J. D'Elia, M.D. Neptune City
 I. Edward Orna, M.D. Camden
 Consultants:
 Samuel J. Lloyd, M.D., *Treasurer* ... Trenton
 Nicholas E. Marchione, M.D., *Chairman, Finance*
and Budget Committee ... Vineland

Bicentennial Celebration, Committee on National

(Established by Board of Trustees to investigate the
 possibility of MSNJ's participation in the National
 Bicentennial Celebration in 1976—7/19/70)
 Morris H. Saffron, M.D., *Chairman* ... Passaic
 David R. Brewer, Jr., M.D. Woodbury
 Peter J. Guthorn, M.D. Neptune City
 Fred B. Rogers, M.D. Trenton

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank
 Association—4/25/69)
 Harry B. Lockhead, M.D. Woodbury

Blood Bank Commission of New Jersey

- (1) Formation of Commission authorized by 1953
 House of Delegates
 Authorized agent of MSNJ in approved Blood
 Bank Programs
- (2) Appointment of two representatives requested by
 Commission—4/5/54
 Jerome G. Kaufman, M.D. Maplewood
 John J. Torppey, M.D. Newark

Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP
 —4/16/60)

A. Guy Campo, M.D., *Chairman*,
Board of Trustees ... Westville
 E. Vernon Davis, M.D., *President* ... Mount Holly
 Mr. Richard I. Nevin, *Executive Director* ... Trenton
 Equal representation from:
 Medical-Surgical Plan of New Jersey
 Hospital Service Plan of New Jersey
 New Jersey Hospital Association

Board of Control, Department of Institutions and Agencies

(Appointed by Governor for 8-year term)
 Frank J. Hughes, M.D. Gloucester

Board of Nursing, New Jersey State

(Liaison requested by Board of Nursing—11/21/65)
 Jesse McCall, M.D. Newton

Bookkeeping, Accounting, and Billing System, Ad Hoc Committee to Establish a Statewide Automated

(Established at request of the 1970 House of
 Delegates)

Louis F. Albright, M.D., *Secretary* ... Spring Lake
 Samuel J. Lloyd, M.D., *Treasurer* ... Trenton
 Nicholas E. Marchione, M.D., *Chairman*,
Finance and Budget Committee ... Vineland
 Mr. Robert H. Lambert, *Business Manager* ... Trenton

Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of
 Law and Public Safety—9/61)
 Board of Trustees

Cardiac Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic
 Safety—9/17/61 ... appointed by Director of Motor
 Vehicles)
 Jerome G. Kaufman, M.D., *Chairman* ... Maplewood
 James G. Kehler, M.D. Woodbury
 Jesse McCall, M.D. Newton
 John C. Wood, M.D. Trenton

Chamber of Commerce Legislative Conferences

(Invited by Chamber—1/15/61)
 Mr. Richard I. Nevin, *Executive Director* ... Trenton

Chronic Sick State Advisory Council

(Commissioner of Health requested MSNJ submit
 names to Governor—10/16/60) ... appointed by
 Governor for 3-year term)
 David Eckstein, M.D. (1971) ... Trenton

Civil Defense Organization, Liaison with State

(Liaison established by MSNJ—5/22/55)
 Jack R. Karel, M.D., *Chairman, Committee on*
Emergency Medical Care ... Hillside

Community Medicine Advisory Council

(MSNJ representation requested by Richard J. Cross,
 M.D., CMDNJ at Rutgers—12/20/70)
 Arthur Bernstein, M.D. Maplewood
 Harold L. Colburn, Jr., M.D. Mount Holly

Comprehensive Health Planning Agency

(Liaison requested by the Comprehensive Health Planning Agency 12/16/69)

Nicholas E. Marchione, M.D., *State Health Planning Council* Vineland
Irving P. Borsher, M.D., *Health Care Costs Committee* Newark
Arthur Bernstein, M.D., *Medicaid Committee* Maplewood
James A. Rogers, M.D., *Medical Education Facilities Committee* Paterson

Crippled Children Commission, State

(Nominated by B/T 28 July 1971—5-year term
Frederick G. Dilger, M.D. (May 1976) Hackensack

Diabetes Detection Drive

(Liaison representative for annual drive—co-sponsored by State Department of Health, New Jersey Diabetes Association, and MSNJ—appointed at request of Commissioner of Health—5/16/54)
John J. Torppey, M.D. Newark

Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP—8/21/60—Quorum: 4 members)

1st District —
Ralph M. L. Buchanan, M.D., Phillipsburg
Chairman
Robert F. Zimmerman, M.D. Morristown
2nd District —
John J. Bedrick, M.D. Bayonne
Robert A. Cosgrove, M.D. Jersey City
3rd District —
John S. VanMater, M.D. New Brunswick
John A. Kinczel, M.D. Trenton
4th District —
John C. Clark, M.D. Asbury Park
Robert S. Gamon, Jr., M.D. Cherry Hill
5th District —
A. Guy Campo, M.D. Westville
Nicholas E. Marchione, M.D. Vineland

Education, State Department of

(Liaison requested by the Assistant Commissioner of Education—9/21/58)

William J. Farley, M.D., *Chairman, Special Committee on Child Health* Nutley

Emotionally Disturbed Child, Advisory Council to Department of Education

(Liaison requested by Department of Education—10/28/68)

William J. Farley, M.D. Nutley

Epilepsy, Advisory Panel to State Director of Motor Vehicles
(Established at request of Director of Motor Vehicles—7/29/66)

J. Berkeley Gordon, M.D. Rumson

Executive Committee

(Provided in the Bylaws, Chapter IV, Section 5 (b))
E. Vernon Davis, M.D., *President* Mount Holly
William J. D'Elia, M.D., *President-Elect* Neptune City
Matthew E. Boylan, M.D.,
First Vice-President Jersey City
James A. Rogers, M.D.,
Second Vice-President Paterson
A. Guy Campo, *Chairman*
Board of Trustees Westville

Eye Medication, Conference Committee on the Control of (Established by Board of Trustees—4/20/69)

Samuel J. Lloyd, M.D., *Chairman, Representative of the Board of Trustees* Trenton
Jesse McCall, M.D., *Chairman, Council on Legislation* Newton
Henry J. Mineur, M.D., *Vice-Chairman, Council on Legislation* Cranford
Frank B. Vanderbeek, M.D., *Chairman, Committee on Conservation of Vision, Hearing, and Speech* Paterson
D. Blair Sulouff, M.D., *Member, Committee on Conservation of Vision, Hearing, and Speech* Morristown
Mr. E. Powers Mincher, *Legal Counsel* Pennington
Mr. Richard I. Nevin, *Executive Director* Trenton
Mr. Vincent A. Maressa, *Executive Assistant* Trenton
Representatives of the New Jersey Academy of Ophthalmology and Otolaryngology
Alfonse A. Cinotti, M.D. Jersey City
John Scillieri, M.D. Paterson
Reginald J. Raban, M.D. Cherry Hill

Fluoridation, Joint Committee on

(Established at request of State Department of Health)

Edwin H. Albano, M.D. East Orange
Robert G. Salasin, M.D. North Wildwood
Equal representation from:
State Department of Health
New Jersey State Dental Society

Health Careers Service, New Jersey

(Physician representation established by Board of Trustees 7/20/69)

Karl T. Franzoni, M.D. Trenton

Health Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers Service—7/19/64)

Presidents of Component Societies

Health Insurance Conference

(Committee established at request of Health Insurance Council—3/24/57)

Jerome G. Kaufman, M.D., *Chairman* Maplewood
Charles L. Cuniff, M.D. Jersey City
E. Vernon Davis, M.D., *President* Mount Holly
William J. D'Elia, M.D., Neptune City
President-Elect
Matthew E. Boylan, M.D., *First Vice-President* Jersey City
James A. Rogers, M.D., *Second Vice-President* Paterson
Mr. Richard I. Nevin, *Executive Director* Trenton

Heart Disease, Cancer, and Stroke

University City Science Center, Philadelphia
(Established at invitation of University City Science Center—12/65)

Louis K. Collins, M.D. Glassboro

Historian-Archivist

(Created at the suggestion of the Executive Director—1/13/57)

Morris H. Saffron, M.D. (Appointed 5/67) Passaic

Hospital Association, New Jersey

(Invitation extended to Executive Director to serve on the Board of Trustees—12/17/67)

Mr. Richard I. Nevin, *Executive Director* Trenton

**Hospital Advisory Council, State Department of
Institutions and Agencies**

(Appointed by the Board of Control for a 4-year term)
Luke A. Mulligan, M.D. (December 1972) . . . Leonia

House Maintenance, Staff Policies, and Personnel Relations
(Special Committee created by Board of Trustees —
9/21/58)

E. Vernon Davis, M.D., *President*
(*Chairman*) Mount Holly
William J. D'Elia, M.D., *President-Elect* . . . Neptune City
Louis F. Albright, M.D., *Secretary* Spring Lake
Samuel J. Lloyd, M.D., *Treasurer* Trenton
A. Guy Campo, M.D., *Chairman, Board of*
Trustees Westville
Nicholas E. Marchione, M.D., *Chairman,*
Committee on Finance and Budget Vineland
Mr. Richard I. Nevin, *Executive Director* . . . Trenton

**HRET (Hospital Research and Educational Trust of New
Jersey), Advisory Council to**

(MSNJ representative requested by HRET. Appointment
made by President 2/13/71. Council will
assist HRET in processing data previously handled
by State Health Facilities Planning Council.)
Mr. Vincent A. Maressa, *Executive Assistant* . . . Trenton

Industrial Safety Board, New Jersey

(Nominated by B/T 26 July 1971)
Delma W. Caldwell, M.D. Linden
Mathilda R. Vashak, M.D. New Brunswick
Elmer J. Elias, M.D. Trenton

Intra-Hospital Infections, Joint Committee on

(Established at request of Commissioner of Health —
4/8/62)

Edwin H. Albano, M.D., *Chairman* East Orange
Lawrence Gilbert, M.D. Irvington
Thomas K. Rathmell, M.D. Trenton
Eugene H. Kain, M.D. Pennsauken

Equal representation from:

State Department of Health
New Jersey Hospital Association
New Jersey State Nurses' Association

JEMPAC, Conference Committee with

(Established at request of JEMPAC — 6/25/67)

Jesse McCall, M.D., *Chairman,*
Council on Legislation Newton
Louis K. Collins, M.D., *Chairman,*
Council on Medical Services Glassboro
James A. Rogers, M.D., *Second*
Vice-President Paterson

**Judiciary and Bar, Conference Committee on
Inter-Relations with the**

(Established at invitation of Supreme Court—11/17/63)

Louis F. Albright, M.D. Spring Lake
Nicholas A. Bertha, M.D. Wharton
William J. D'Elia, M.D. Neptune City
Jerome G. Kaufman, M.D. Maplewood
Samuel J. Lloyd, M.D. Trenton
Nicholas E. Marchione, M.D. . . . Vineland
Jesse McCall, M.D. Newton
Emanuel M. Satulsky, M.D. Elizabeth
E. Vernon Davis, M.D., *President,*

Ex-officio

Mount Holly
Mr. Richard I. Nevin, *Executive Director* . . . Trenton
Mr. Vincent A. Maressa, *Executive Assistant* . . . Trenton
Mr. E. Powers Mincher, *Legal Counsel* . . . Pennington

Equal representation from:

Supreme Court Committee on Relations with the
Medical Profession

**Legal Documents, Committee on Extension to Interns
and Residents of Power to Sign Certain**

(Established at request of 1969 House of Delegates)

Nicholas A. Bertha, M.D., *Chairman* Wharton
Henry J. Mineur, M.D. Cranford
Emanuel M. Satulsky, M.D. Elizabeth

Legislation

- (1) Federal Keymen
(Mechanism established by MSNJ — 4/4/54 . . . to
serve as official intermediaries between MSNJ and
the Federal legislators)
15 Congressional District Keymen
1 Senatorial Keyman
- (2) State Keymen
(Mechanism established by MSNJ — 7/13/52)
Keymen in 15 Legislative Districts/21 Compon-
ent Societies

Medicaid, Negotiating Committee For

(Established by Board of Trustees to work with the
State Medicaid Commission — 12/22/68)

E. Vernon Davis, M.D., *President* Mount Holly
William J. D'Elia, M.D., *President-*
Elect Neptune City
Louis K. Collins, M.D., *Chairman,*
Council on Medical Services Glassboro
Associate Members:
Jesse McCall, M.D., *Chairman,*
Council on Legislation Newton
Henry J. Mineur, M.D., *Vice-Chairman,*
Council on Legislation Cranford
Frank M. Galito, M.D., *Vice-Chairman,*
Council on Medical Services Bloomfield
Joseph A. Lepree, M.D., *Representative of 1st*
Judicial District Elizabeth
Karl T. Franzoni, M.D., *Representative of 3rd*
Judicial District Trenton
Robert S. Gamon, Jr., M.D., *Representative of*
4th Judicial District Cherry Hill

Medicaid Peer Review Committee

(Established by Board of Trustees 4/19/70 at the re-
quest of the Department of Institutions and Agencies.
The function of the Committee will be to act upon
inquiries and/or complaints originating either with
the administrators of the Medicaid Program or with
physicians serving under the program.)

1st District —
Nicholas A. Bertha, M.D. Wharton
2nd District —
Ambrose P. Boyle, Jr., M.D. Fort Lee
3rd District —
David Eckstein, M.D. Trenton
4th District —
Emanuel Abraham, M.D. Asbury Park
5th District —
Mario Pastore, M.D. Ocean City

Medicaid Program, Medical Advisory Committee to the

(Appointment of four representatives requested by
Department of Institutions and Agencies — 6/12/69)
George E. Barbour, M.D. Somerville
Donald P. Burt, M.D. Morristown
Arthur C. Dietrick, M.D. Mount Holly
John D. Franzoni, M.D. Trenton

Medical Advances and Planning, Steering Committee on

(Established by Board of Trustees 5/15/70. This Com-
mittee will be charged with the duty of organizing a
statewide Department on Medical Advances, which,
hopefully, would succeed in stimulating the interest
of physicians, coordinating existing activities, and

eliminating needless duplications in program offerings.)
 Nicholas A. Bertha, M.D. Wharton
 James A. Rogers, M.D. Paterson
 2 Representatives from the Directors of Medical Education
 2 Representatives from each of the medical schools

Medical Assistance Advisory Council

(Established at invitation of State Medicaid Commission — 4/20/69)
 A. Guy Campo, M.D. Westville
 Anthony P. DeSpirito, M.D. Asbury Park

Medical Assistants, New Jersey Association of

(Liaison requested by Association — 9/15/63)
 Robert C. Anderson, M.D. Newark

Medical-Hospital-Nursing Conference (Tri-Partite)

(Liaison established by MSNJ — 1/13/57)
 E. Vernon Davis, M.D., *President* Mount Holly
 William J. D'Elia, *President-Elect* Neptune City
 Emanuel M. Satulsky, M.D., *Immediate Past-President* Elizabeth
 Mr. Richard I. Nevin, *Executive Director* Trenton
 Equal representation from:
 New Jersey Hospital Association
 New Jersey State Nurses' Association

Medical Liaison Committees

(High-level conference groups for discussion and consideration of items of mutual interest)
 E. Vernon Davis, M.D., *President* Mount Holly
 William J. D'Elia, M.D., *President-Elect* Neptune City
 Emanuel M. Satulsky, M.D., *Immediate Past-President* Elizabeth
 Mr. Richard I. Nevin, *Executive Director* Trenton
 (Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)
 (1) Medical-Dental
 (Liaison requested by the Dental Society — 6/10/51)
 (2) Medical-Hospital
 (Liaison established by MSNJ — 10/25/53)
 (3) Medical-Legal
 (Liaison established by MSNJ — 10/25/53)
 (4) Medical-Nursing
 (Liaison established by MSNJ — 4/4/54)
 (5) Medical-Osteopathic
 (Liaison requested by Osteopathic Association — 9/17/61)
 (6) Medical-Pharmaceutical
 (Liaison established by MSNJ — 7/26/53)

Medical School in South Jersey, Committee to Assist in the Implementation of Legislation to Establish a

(Established by Board — 5/17/67 — Appointments by President)
 Louis K. Collins, M.D., *Chairman* Glassboro
 A. Guy Campo, M.D. Westville
 Sherman Garrison, M.D. Bridgeton
 Frank J. Hughes Gloucester
 Jerome G. Kaufman, M.D. Maplewood
 John F. Kustrup, M.D. Trenton
 Fred A. Mettler, M.D. Blairstown
 James A. Rogers, M.D. Paterson

Medical Schools in New Jersey, Ad Hoc Committee on Development of

(Established by Board — 9/20/64)
 E. Vernon Davis, M.D., *President* Mount Holly
 William J. D'Elia, M.D., *President-Elect* Neptune City
 Sherman Garrison, M.D. Bridgeton

Jerome G. Kaufman, M.D. Maplewood
 Fred A. Mettler, M.D. Blairstown
 James A. Rogers, M.D. Paterson

Medical-Surgical Plan Board of Trustees

(Provided in MSP Bylaws)
 E. Vernon Davis, M.D., *President* Mount Holly

Medicare, Committee on Utilization of Physicians' Services under Part B

(Established at request of 1969 House of Delegates)
 Nicholas A. Bertha, M.D., *Chairman* Wharton
 John F. Kustrup, M.D. Trenton
 Emanuel M. Satulsky, M.D. Elizabeth

Medicare Claims Inquiry Committee, Joint

(Established by Board of Trustees 11/16/69 to provide physicians, who feel their fees have been arbitrarily reduced, or who have other bases of dissatisfaction, with a forum for discussion.)
Representing The Medical Society of New Jersey:
 E. Vernon Davis, M.D., *President*
 William J. D'Elia, M.D., *President-Elect*
 Louis F. Albright, M.D., *Secretary*
 Donald T. Akey, M.D.
 Mr. Richard I. Nevin, *Executive Director*

Representing the Fiscal Intermediary:

Mr. William C. White, Jr., C.L.U., *Vice President*
 Mr. Everett J. Park, F.L.M.I., *General Manager*
 James E. Brennan, M.D., *Medical Director*
 Mr. Thomas J. Beatty, *Associate General Manager*
 Mr. Wilfred I. Meyers, *Associate Director*

Medicare Law (P.L. 89-97)

(Assigned by the Board — 10/17/65 as indicated below)

- (1) Over-all responsibility to study and provide recommendations concerning the Medicare Program
 Council on Medical Services
 Consultants to the Council on Medical Services:
 E. Vernon Davis, M.D., *President* Mount Holly
 William J. D'Elia, M.D., *President-Elect* Neptune City
 Jesse McCall, M.D., *Chairman* Newton
 Council on Legislation
 Robert G. Salasin, M.D., *Chairman* North Wildwood
 on Public Health
 Frank J. Hughes, M.D., *Member*, New Jersey Board of Control Gloucester
- (2) Liaison representative to State Department of Health
 (Established by MSNJ — 1/16/66)
 David Eckstein, M.D. Trenton
- (3) Liaison representatives to State Department of Institutions & Agencies
 (Established by MSNJ — 1/16/66)
 Francis J. Benz, M.D. Chatham
 Louis K. Collins, M.D., *Chairman*, Council on Medical Services Glassboro
 Mr. Vincent A. Maressa, *Executive Assistant* Trenton
- (4) Home-Hospital-Nursing Care
 (Liaison established by MSNJ — 3/20/66)
 Matthew E. Boylan, M.D. Jersey City

Medicare Peer Review Committee

(Established by Board of Trustees 12/20/70 at request of fiscal intermediary. Committee will review and evaluate claims involving questions of over-utilization under Medicare. Composition of committee includes five groups of three members each in the fields of general practice, general surgery, internal medicine, ophthalmology, and urology.)

Membership Directory

(Special committee established by Board — 11/19/61)
 Louis F. Albright, M.D., *Chairman* Spring Lake
 Robert C. Anderson, M.D. Newark
 John J. Bedrick, M.D. Bayonne
 Matthew E. Boylan, M.D. Jersey City
 George B. Sharbaugh, M.D. Trenton
 Mr. Richard I. Nevin, *Executive Director* Trenton
 Mr. Robert H. Lambert, *Business Manager* Trenton

Neurological Diseases, Advisory Council to New Jersey Consultation Service for Convulsive Disorders

(Liaison established — 7/19/64)

Robert S. Garber, M.D. Belle Mead

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter — 1/26/60)

George E. Barbour, M.D. Somerville

Nursing Education and Recruitment, Permanent Committee on

(Established by direction of 1963 House of Delegates)

Jesse McCall, M.D., *Chairman* Newton

George E. Barbour, M.D. Somerville

William P. Mulford, M.D. Beverly

Lewis E. Savel, M.D. South Orange

Mr. Richard I. Nevin, *Executive Director* Trenton

Equal representation from:

New Jersey Hospital Association

New Jersey League for Nurses

New Jersey State Nurses' Association

Administrators of Nursing Schools

Advisors (2) from State Department of Education

Nutrition Council, New Jersey

(Liaison established by MSNJ — 12/19/54)

Harvey P. Finhorn, M.D. South Orange

Ochampus (Office for the Civilian Health and Medical Program of the Uniformed Services)

(1) Fiscal Agent

(Designated upon request of MSP — 7/21/63)

Medical-Surgical Plan of New Jersey

(2) Special Committee on

(Established by MSNJ — 9/9/56)

George E. Barbour, M.D., *Chairman* Somerville

George L. Benz, M.D. Newark

David Eckstein, M.D. Trenton

I. Edward Orna, M.D. Cherry Hill

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health — 12/20/64)

William J. Farley, M.D. Nutley

Pension Plan, Special Committee on

(Established by Board — 5/22/55 . . . Duties outlined in Article III of Pension Plan Agreement)

Nicholas E. Marchione, M.D., *Chairman*, *Committee on Finance and Budget* Vineland

F. Vernon Davis, M.D., *Chairman*, *Special Committee on House Maintenance, Staff Policies, and Personnel Relations* Mount Holly

Samuel J. Lloyd, M.D., *Treasurer* Trenton

Planning and Development, Committee on Long Range

(Established by Board of Trustees 2/21/71. The charge to this committee is to look to future to devise policies and strategies which will improve the structure and operations of MSNJ.)

Louis F. Albright, M.D., *Chairman* Spring Lake

Arthur Bernstein, M.D. Maplewood

Nicholas A. Bertha, M.D. Wharton

Frederick W. Durham, M.D. Haddonfield

David Eckstein, M.D. Trenton

Karl L. Franzoni, M.D. Trenton

John F. Kustrup, M.D. Trenton

Nicholas E. Marchione, M.D. Vineland

Public Health Association, New Jersey

(1) Membership authorized by Board — 11/15/59

Joseph R. Jehl, M.D. (*Delegate*) Clifton

Mr. Richard I. Nevin (*Alternate*) Trenton

(2) Animal (Medical) Research

(Liaison representative requested — 4/17/66)

Edwin H. Albano, M.D. East Orange

(3) Medical Care Committee

(Association requested physician to serve as chairman of its Medical Care Committee — 2/24/65)

John J. Bedrick, M.D. Bayonne

Public Health Council, State Department of Health

(Nominations for appointment by Governor requested — 9/20/64)

Harry Mickey, M.D. Maplewood

Quackery, Committee on

(Established at the request of the AMA — 11/15/64)

Henry J. Mineur, M.D., *Chairman* Cranford

Charles B. Norton, M.D. Woodstown

James S. Todd, M.D. Ridgewood

Radiation Protection Commission, Consultant to New Jersey

(Nomination for appointment to Commission requested — 7/18/65)

Bernard M. Schnur, M.D. Trenton

Radiation Protection Commission, New Jersey

(Two consultants in nuclear medicine requested by the Commission 11/66)

Frank Schell, M.D. Wayne

John J. Thompson, M.D. Caldwell

Regional Planning Council, Philadelphia Medical Library Committee

(Appointment of representative requested by Library Committee — 8/20/67)

Sherman Garrison, M.D. Bridgeton

Rehabilitation Commission, New Jersey State

(Liaison requested by MSNJ's Committee on Rehabilitation — 5/65)

Carl A. Maxwell, M.D. Phillipsburg

Safety Council, New Jersey State

(Provided in Council Bylaws)

F. Vernon Davis, M.D., *President* Mount Holly

Delma W. Caldwell, M.D., *President's Representative* Linden

Selective Service System, New Jersey Chairman of Advisory Committee to

(Nomination for appointment by National Advisory Committee requested by committee — 11/19/61)

Jesse McCall, M.D. Newton

Statutes Related to the Practice of Medicine and Surgery in New Jersey, Committee to Review

(Established by MSNJ to implement substitute resolutions 7 & 8, 1967 House)

Nicholas A. Bertha, M.D., *Chairman* Wharton

Thomas C. DeCecio, M.D. Cliffside Park

Samuel J. Lloyd, M.D. Trenton

Mr. Richard I. Nevin, *Executive Director* Trenton

Mr. Vincent A. Maressa, *Executive Assistant* Trenton

Mr. E. Powers Muncher, *Legal Counsel* Pennington

Welfare Council, New Jersey

(Representative to plan meetings for annual conference on social welfare requested by council — 5/13/66)

John J. Bedrick, M.D. Bayonne

Widows and Orphans of Medical Men of New Jersey, Society for Relief of

(Liaison requested by Society — 5/17/59)

Joseph R. Jehl, M.D. Clifton

ANNOUNCEMENTS

Trauma Seminar

Starting at 9 a.m., on Saturday, September 25, at the Jersey City Medical Center, the New Jersey Committee on Trauma (of the American College of Surgeons) will conduct a trauma seminar. Presentations will be offered by an outstanding faculty, and will include such topics as alkalosis and oxygenation, wounds of the heart, infections of the hand, emergency facilities, tetanus, sepsis, and pulmonary insufficiency.

The program is also sponsored by the College of Medicine and Dentistry of New Jersey and the Jersey City Medical Center. The fee for registration and luncheon reservation is \$10. Please send your check (payable to the New Jersey Committee on Trauma) to Clifford B. Blasi, M.D., Chairman, New Jersey Committee on Trauma, Jersey City Medical Center, Jersey City, New Jersey 07304.

Clinical Application of Basic Sciences

The Burlington County Memorial Hospital announces the following programs for October, in its series, "Clinical Application of Basic Sciences." AAGP will credit 1½ points per session.

October 7 The Doctor-Patient Relationship
October 14 Masked Depression in Medical Practice
October 21 Influence of Language upon Symptomatology in Foreign-Born Patients
October 28 Unusual Post-Surgical Pain

All programs are presented in the T. J. Summey Building of the Burlington County Memorial Hospital, and begin promptly at 3:30 p.m. For further information, please contact the Department of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Courses For Ophthalmologists

For the 14th consecutive year, the New York

Eye and Ear Infirmary is launching advanced courses for ophthalmologists. This year's program begins in October 1971 and includes cadaver dissection of the orbit and adnexae, lid and orbital plastic surgery, ultrasonography, ocular geriatrics, use of radio-isotopes, reading disabilities, tonometry, lacrimal sac surgery, and microsurgery. For details write to Registrar of the Graduate Institute, Eye and Ear Infirmary, 310 East 14th Street, New York 10003.

Course on OB-GYN Pathology

From October 25 through October 29, at the Saint Barnabas Medical Center in Livingston, a course in obstetric and gynecologic pathology will be offered by that hospital. This is a survey of the female genital tract from a clinical and histopathologic view. Gross and microscopic materials will be examined and correlated with the clinical picture of the disease under study, including diagnosis and therapy. Tuition is \$250 (\$125 for residents) and the course is limited to fifty applicants. For further information, please write to James L. Breen, M.D., Director, Department of Obstetrics and Gynecology, Saint Barnabas Medical Center, Old Short Hills Road, Livingston, New Jersey 07039.

Cytology Meeting in November

The American Society of Cytology announces its annual scientific program to be held in Washington, D.C. (Hilton Hotel), November 3 to 6, 1971. For more details, please write to Warren R. Lang, M.D., 7112 Lincoln Drive, Philadelphia, Pennsylvania 19119.

Program on Exercise and the Heart

The AMA Committee on Exercise and Physical Fitness, the Pennsylvania Heart Association, and the President's Council on Physi-

cal Fitness will jointly sponsor a program on exercise and the heart—to be held from 2 to 5 p.m. on Monday, November 8 at the Host Farm Motel in Lancaster, Pennsylvania. The meeting is open to both physicians and allied health personnel, and will be held in conjunction with the scientific assembly of the Pennsylvania Medical Society. Included will be presentations on exercise for well patients, exercise following cardiovascular illness, and conditioning exercises in physical fitness. The tuition is \$10 for physicians and \$5 for allied health personnel. For further information, please write to Fred V. Hein, Ph.D., Secretary, Committee on Exercise and Physical Fitness, American Medical Association, 535 North Dearborn Street, Chicago 60610.

Symposium on EENT

On November 10, at the Robert Treat Hotel in Newark, the New Jersey Academy of Ophthalmology and Otolaryngology will hold its regular annual meeting. The program is divided into two sections—one on the eye and the other on ear, nose, and throat—and a star-studded faculty has been selected to present papers on such subjects as corneal ulcers and burns, retinal detachments, photocoagulation therapy, oblique palsy, cataract surgery, salivary gland tumors, carcinoma of head and neck, correction of the nasal tip, retro-malleolar fascia slot grafting, and mediostinoscopy. For further information, please write to the Secretary of the Academy, John Scillieri, M.D., at 220 Engle Street, Englewood, New Jersey 07631.

Family Practice Examination

The American Board of Family Practice announces that it will give its next examination for certification in various centers throughout the United States. The examination will be over a two-day period on April 29 and 30, 1972. Information regarding the examination may be obtained by writing to Nicholas J. Pisacano, M.D., Secretary, American Board of

Family Practice, University of Kentucky Medical Center, Annex 2, Room 229, Lexington, Kentucky 40506. Deadline for completed applications is February 1, 1972.

Breast: Tumors and Reconstruction

The American Society of Plastic and Reconstructive Surgeons is giving a two-day symposium, February 4 and 5, 1972, in conjunction with the Sloan-Kettering Cancer Center, on problems of the female breast. The program includes methods in use, augmentation of the breast, mammoplasties, mastectomies, and reconstruction after mastectomy. The fee is \$100 and registration is limited. For more details, please write to Reuven K. Snyderman, M.D., Memorial Sloan-Kettering Cancer Center, 444 East 68th Street, New York, 10021.

Proctology Seminar

The next Congress and Teaching Seminar of the International Academy of Proctology will be held at the Town and Country Hotel, San Diego, California, April 7 to 14, 1972. Scientific sessions are planned for Monday through Thursday, April 10 to 13. All physicians are invited to attend these, at which time physicians from abroad and the United States are scheduled to present many worthwhile papers. Further information may be obtained from the International Academy of Proctology, 147-41 Sanford Avenue, Flushing, New York 11355.

ATTENTION COMPONENT SOCIETIES

Please Note!

The 206th Annual Meeting of MSNJ will be held **May 6 to 9, 1972**. Please schedule your county meeting for election of delegates and alternate delegates so that the names can be forwarded to the Executive Offices no later than **April 1, 1972**.



Additional information available to the profession on request.
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gastritis

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It provides prompt, pronounced, prolonged suppression of gastric hypersecretion, making it a highly effective agent in gastritis and other upper G-I conditions associated with hypersecretion and hypermotility.

Because Robinul Forte exerts a profound antispasmodic action, it is also useful in the treatment of lower G-I disorders, such as functional bowel distress and spastic and irritable colon. If the patient has a “one tract mind” concerning his condition, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital—warning: may be habit forming).

Robinul® 2mg. Forte (glycopyrrolate)

INDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with acute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic pancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure syndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital may be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient glaucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 1 to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Blurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic drugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one tablet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum required to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

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MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

September

- 8 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Hypertensive Physiology and Treatment
- 9 Burlington County Memorial Hospital
Mount Holly
Angina Without Obstructive Coronary Disease
- 13-17 Academy of Medicine of New Jersey
University of Rome and University of Belgrade
Postgraduate Medical Symposium
- 16 Burlington County Memorial Hospital
Mount Holly
Management of Coronary Patients from the Acute to Extended Care of Convalescence
- 20 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Building a Personal Medical Library
- 22 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Effect of Gynecologic System on Urologic System
- 23 Burlington County Memorial Hospital
Mount Holly
The Evaluation of Patients for Surgical Treatment of Coronary Artery Disease
- 29 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Acute Renal Failure
- 30 Burlington County Memorial Hospital
Mount Holly
Experience in Surgery for Coronary Heart Disease

October

- 5 Academy of Medicine of New Jersey
Holy Name Hospital
Teaneck
Hypertension and the Newer Diuretics

- 6 American Academy of General Practice, the Academy of Medicine of New Jersey, and Middlesex General Hospital
Middlesex General Hospital
New Brunswick
Recent Advances in Internal Medicine and Therapeutics
- 7 Burlington County Memorial Hospital
Mount Holly
The Doctor-Patient Relationship
- 13 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Kidney Functions
- 14 Burlington County Memorial Hospital
Mount Holly
Masked Depression in Medical Practice
- 20 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Recurrent Fevers of Unknown Etiology
- 21 Burlington County Memorial Hospital
Mount Holly
The Influence of Language upon Symptomatology in Foreign-born Patients
- 25-29 Saint Barnabas Medical Center
Livingston
Obstetric and Gynecologic Pathology
- 27 Academy of Medicine of New Jersey
Saint Michael's Medical Center,
Newark
Hospital Acquired Infections
- 28 Burlington County Memorial Hospital
Mount Holly
Unusual Post Surgical Pain

November

- 4 Burlington County Memorial Hospital
Mount Holly
Cranio-Cerebral Trauma
- 10 New Jersey Dental Association
Semi-Annual Session

- 10 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Chronic Renal Disease and Dialysis
- 10 Academy of Medicine of New Jersey
Hoffmann-La Roche, Nutley
Alcoholism
- 11 Burlington County Memorial Hospital
Mount Holly
Crushing Injuries of the Chest
- 17 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Pharmacology of Diuretics, Indications and Use
- 18 Burlington County Memorial Hospital
Mount Holly
Peritoneal Dialysis in the Community Hospital
- 24 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Electrolyte Imbalance

December

- 1 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Urology, Including Prostatic Disease
- 2-3 Saint Barnabas Medical Center
Livingston
Gynecological Endoscopy
- 2 Burlington County Memorial Hospital
Interservice Seminar
- 8 Academy of Medicine of New Jersey
Saint Michael's Medical Center,
Newark
Urinary Tract Infections

Dr. William C. Wilentz Retires

The State's senior County Medical Examiner, William C. Wilentz, M.D., has been chief medical examiner of Middlesex County since 1933. He retired from that position in July 1971 and received an editorial accolade from the New Brunswick *Daily Home News*, in his home county.

- 8 Academy of Medicine of New Jersey
Bergen Pines Hospital
Paramus
Pacemaker; Electrode and Vascular Surgery
- 9 Burlington County Memorial Hospital
Mount Holly
The Management of Suspected Testicular Neoplasm
- 11 Academy of Medicine of New Jersey
Section on Dermatology
- 16 Burlington County Memorial Hospital
Mount Holly
Medical and Surgical Management of Urolithiasis
- 30 Burlington County Memorial Hospital
Mount Holly
Evaluation and Management of the Arthritic Hip

1972

January

- 6 Burlington County Memorial Hospital
Mount Holly
Viral Hepatitis: A Reappraisal of Mild Hypertension
- 11 Academy of Medicine of New Jersey
Bloomfield
Sectional Meeting: Dermatology
- 13 Burlington County Memorial Hospital
Mount Holly
Current Concepts of Cardiomyopathy
- 19 Academy of Medicine of New Jersey
College of Medicine and Dentistry at Newark
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OBITUARIES

Dr. Robert T. Bryan

A cerebral hemorrhage on May 18, 1971, took the life of Robert T. Bryan, M.D., the 48-year old Director of Laboratories at the Morristown Memorial Hospital. With a medical degree from the University of Arkansas (class of 1950), he did graduate work in pathology, becoming a diplomate in that specialty. After serving as pathologist in hospitals in New York State and in Texas, he came to Morristown in 1966. During World War II he was a staff sergeant in the infantry, and entered medical school after being demobilized from that service.

Dr. Richard R. Chamberlain

Essex County lost one of its most distinguished and useful members on July 7, 1971, with the death of Richard R. Chamberlain, M.D. He was Secretary of the Essex County Medical Society at the time of his death at age 61. He received his M.D. at the University of Virginia in 1934 and came to New Jersey to intern that year at the Orange Memorial Hospital. He was nationally known for his service as Chairman of the AMA Section on General Practice in 1968. A few years earlier, he had been Chairman of the General Practice Section of The Medical Society of New Jersey. When the American Academy of General Practice set up its first Test Committee, he was a member. Dr. Chamberlain was affiliated with St. Barnabas Hospital in Livingston and the Medical Center at Orange. He served a tour of duty as President of the Medical Staff of that hospital in 1960. He was President of the New Jersey Academy of General Practice and of the Clinical Society of the Oranges.

Dr. Sidney Z. Lintz

Born in 1911, Sidney Z. Lintz, M.D., of Swedesboro died on May 8, 1971. He was a general practitioner, active in committee

work for our Gloucester County Medical Society and in the programs of the New Jersey Chapter of the American Academy of General Practice. Dr. Lintz earned his M.D. at the University of Pennsylvania in 1937.

Dr. Carmelo A. Musetto

Carmelo A. Musetto, M.D. was a 1930 graduate of Long Island Medical College. From 1942 to 1946 he served in the United States Navy as a Lieutenant Commander in the Medical Corps. He was a surgeon with special interest in proctology, and was board certified in that specialty. He was on the staff of the Riverside Hospital in Boonton and a member of our Morris County Medical Society. Born in 1906, he was 65 years old at the time of his death on June 30, 1971.

Dr. Harvey Rinzler

A founder of the Community Memorial Hospital in Toms River and a Past-President of the Ocean County Medical Society, Harvey Rinzler, M.D., died on the first day of summer. He was a family doctor with special interest in anesthesiology. He was affiliated with the Paul Kimball Hospital in Lakewood, as well as with the hospital in Toms River. During World War II, he was a major in the Army of the United States. He received his M.D. degree at Bellevue in 1937 at the age of 23.

Dr. Edward P. Seidmon

Born in 1906, Edward P. Seidmon, M.D., died on July 7, 1971. He was a 1932 graduate of the medical school at the University of Illinois, and practiced pediatrics in Chicago until 1940. He then did graduate work in allergy in New York, served as a major in the medical corps of the Army of the United States, and later developed an allergy practice in Plainfield. He was an active member of our Union County Medical Society, and on the staff of the Hunterdon County Medical Center (Flemington) and the Muhlenberg Hospital (Plainfield). For more than a decade, he was a member of our Annual Meeting Committee.

BOOK REVIEWS

Handbook of Pediatrics, 9th Edition. Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D., Los Altos, California, 1971, Lange Publications. Pp. 713. (Softback, price not stated)

Though not intended to be a substitute for a standard pediatric text, this is a comprehensive work, geared to meet the needs of a pediatric house officer, medical student, practicing physician, or pediatrician. It includes chapters outlining the pediatric history and the physical examination; management of illness; growth and development; nutrition and feeding; chemotherapeutic agents and antibiotics. Ruth S. Kempe contributes the chapter on emotional problems. The material on fluid and electrolyte disorders (written by Robert W. Winters) is more than one would expect in a handbook.

The soft cover does not lend itself to longevity. The reviewer's copy became shabby in short order. The inside back cover (which deals with cardiac arrest) is incomplete because dosages for epinephrine, bicarbonate, and calcium are not listed, and this is not a time to cross reference. On the whole, however, the book is well worth having. This ninth edition is a tribute to its usefulness.

Albert P. Rosen, M.D.

Human Relations—Law Enforcement in a Changing World. Alan Coffey, Edward Eldefonso, and Walter Hartinger. Prentice-Hall, Englewood Cliffs, N.J. Pp. 240. (\$9.95)

Law enforcement officers are here offered a basic knowledge of the sociologic and psychologic factors involved in riots, hatred of the police, and civil disturbances. This is a useful source book for physicians called on to give talks before or lead discussions among police officers or recruits. The book stresses the importance of police officials establishing solid and friendly contacts with high school principals, clergymen and social agencies, and urges frequent open houses at police precincts. They recognize that American police have little experience in handling riots among college students, and perhaps too much experience in trying to contain riots among militants in the minority groups. They try to give a reasonable explanation for violence, but yield to no one in their insistence that inadequate enforcement or failure to control mobs is a factor in worsening the problem.

They see college riots as mere manifestations of what they call "youthful exuberance." It does not seem to have occurred to them that sometimes these are expressions of honest dissent and genuine concern about contemporary problems. Indeed, the authors warn that riots in the past have toppled governments.

Certainly police officers who seriously study this book will be given a deeper understanding of riotous or grossly disturbed behavior. Psychologic and sociologic

factors are spelled out and discussed. A sort of Panglossian optimism pervades the text. Thus in London a few years ago, a large crowd demonstrated in front of the U.S. Embassy (can you guess why?). The police handled them gently and at the end of the day a group of weary demonstrators sang "Auld Lang Syne." The bobbies, say the authors, joined in the singing.

If it were only that simple!

HENRY A. DAVIDSON, M.D.

Taste and Smell in Vertebrates. (Ciba Foundation Symposium) Edited by G. E. W. Wolstenholme and Julie Knight. J. & A. Churchill, London, 1970. Pp. 420. (Price not stated)

This is a beautiful illustration in itself of the "scientific" application of some of the greatest technological advances of our civilization. Yet it shows how very sterile some of the most intricate technology can be. Here are numerous illustrations of the fine detail that electronic microscopy has opened up to the scientist. Some of the scanning photographs are scientific works of art. The electroencephalograph also has a role in this book. These are wonderful tools. But one puts down the book with the feeling that perhaps the tools had been working under their own guidance. There seems to be no direction, no central guiding spirit, no goal in this book, no relationship to life, to man, to medicine.

Lowenstein who chaired four other symposia on sensory functions in vertebrates as well as the present one, noted that taste and smell are the "Cinderellas of the senses." This may well be true in more ways than one. For the scientists in this symposium have ignored the beauty of taste and smell. When taken in relation to life and to each other these senses reveal themselves as that basic chemosensory function that enabled the just-originating living organisms to select the salubrious from the environment and to reject the toxic. It is difficult for me to take seriously any symposium on taste and smell that is not related to this fundamental proposition. In a sense, the book is not related to life. Nor is it related to medicine. As this symposium was organized and as published it has only limited value for the medical practitioner.

Harold E. Lippman, M.D.

VD: Facts You Should Know. Andre Blanzaco, M.D. New York, 1970, Lothrop, Lee, and Shepard. Pp. 63. (\$3.95)

This brief factual book is addressed to teenagers. It is clear and simple, and uses repetition and self-testing questions and answers for teaching fundamental facts about gonorrhea and syphilis. The style of writing seems condescending at times. There are a few pages of illustrations, artistically designed, but without any accompanying explanatory text.

The last chapter of the book gives a brief history of the spread of venereal disease throughout our civilized world. Probably because it doesn't try so hard to teach, it makes for much easier reading. A minor fault which I found annoying—and which was commented on by the several young people to whom I showed the book—was the author's use of the words "mating" or "intimate contact" when he meant sexual intercourse. In talking to teenagers today, we really do have to tell it like it is.

LILLIAN ROSENBERG, M.D.

Surgery and Biology of Wound Repair. Erle E. Peacock, Jr., M.D. and Walton Van Winkle, Jr., M.D. Philadelphia, 1970, Saunders. Pp. 630. Illustrations 338. (\$21.50)

Peacock and Van Winkle have undertaken a monumental task, presenting a definitive book on wound healing. They are to be admired for handling it in such a fine fashion. The book embraces the entire field of wound healing from the cellular response to injury (particularly produced by the surgeon's knife) where the usual inflammatory action subsides in about five days to granulomatous tissue response.

The biochemical sections on wounds and their make-up are very good. Portions are devoted to tendon, fascia and muscle, peripheral nerve, and bone repair. The comments on control of abdominal adhesions are very pertinent particularly when one realizes that this enormously important problem is not yet completely solved. All surgeons will profit from reading the section on "wound contraction in humans," which is illustrated dramatically.

The book will be of service to surgeons in general and contains clinical and basic science material which is formulated and presented very nicely. Medical libraries will find considerable demand for the book. It will be of use to surgeons in their own private libraries. It is attractively bound and covered and the type composition is sharp. This book is recommended highly.

ROBERT K. SPIRO, M.D.

Clinical Treatment of Back and Neck Pain. Hans Kraus, M.D., McGraw-Hill, New York, 1970. Pp. 156. (Price not stated)

Back pain and neck pain are here seen as local disorders related to inadequate exercise, poor posture, and emotional stress. The author describes a technic for examination which stresses the finding of trigger points, the appraisal of the function of the muscles of posture and the assay of muscle tension. Treatment is presented in terms of proper exercise, keeping the patient ambulatory, use of surface anesthetics, and physical therapy.

Joseph Leo Barone, M.D.

Molecular Properties of Drug Receptors (Ciba Symposium) Ruth Porter and Maeve O'Connor, Editors. Baltimore, 1971, Williams and Wilkins. Pp. 298. Illustrated. (Price not stated)

Dr. F. H. C. Crick, of "double helix" fame, chaired this symposium which was held in January, 1970. It is introduced by a general review of the pharmacologic properties of receptors, followed by specific reports on the receptors of cholinergic, adrenergic, and motor endplate postsynaptic membrane systems. There are then papers on active sites in enzymes, including crystallographic studies of lysozyme and nuclear magnetic resonance studies of staphylococcal nuclease. Included also are studies on conformational changes in proteins studied by fluorescent probes, interactions of subunits of hemoglobin, and conformational transitions in the course of membrane excitation. Finally, there are reports on affinity labeling of protein active sites, counting of acetylcholine receptors in the electroplax, and general attempts at characterization of receptors. Each report is followed by a discussion among all of the symposium participants.

Only readers equipped with strong backgrounds in molecular biology, pharmacodynamics, biochemistry and physical chemistry should attempt to extract information from this very technical, very basic, and very important symposium. There are no easily found cursives which would allow a stranger to come away from this book feeling he has glimpsed even a small, clear view of this vital field.

HYMAN W. FISLER, M.D.

Sensorineural Hearing Loss. (Ciba Symposium) G. E. W. Wolstenholme and Julie Knight, Editors. Williams and Wilkins, Baltimore, 1971. Pp. 358. Illustrated. (Price not stated.)

Webster's Dictionary defines a symposium as a "Conference at which a particular subject is discussed and opinions gathered." This book would qualify rather vaguely under this definition as there is a tenuous thread connecting the various chapters under the over-all title. All chapters represent papers delivered at the symposium in London in December, 1969. The disadvantage of this type of book is the lack of continuity of subject and continuity of quality. I would, however, recommend that otologists read the chapter by Engstrom, "Organ of Corti and Noise Damage." The illustrations are superb. Also special mention should be made of J. Sade's article, "Otitis Media and Muco-Ciliary System." Many of the chapters are not of deep interest to the average clinician.

Discussions at the end of each chapter add much to the appreciation of the preceding material and are the best parts of this book. I would suggest that all readers of this book obtain a similar International Symposium, "Sensorineural Hearing Processes and Disorders," given at the Henry Ford Hospital in March 1965. There has been very little new added to this subject since then and if one compares the two books, the new one comes out second best. I would like, however, to recommend this book to the clinical otologist as a reference for some of the excellent chapters and the discussions.

Henry Z. Goldstein, M.D.

Children of Mentally Ill Parents. Elizabeth Rice, M.S., Miriam Ekdahl, M.S.S., and Leo Miller, Ph.D. New York, 1971, Behavioral Publications. Pp. 266. (\$9.95)

Little attention has been paid to the emotional risk (and sometimes the physical risk) to children of emotionally ill parents. Thus, there is much pressure now for early release of adults from mental hospitals, with little concern about the possibly traumatic effect on the children of premature release. In this volume, a study is reported of 652 children who had parents in a Massachusetts State Hospital. It was found that the mother's emotional sickness had more impact on the children than the father's. It was also found that state hospitals seldom seemed to take much interest in the home care of the children of their adult patients. A large proportion of the children seemed to have become upset by the illness of the parent, and a lesser proportion were neglected or abused as a result of the family breakdown. The multiple problems of these children are here spelled out, and the inadequacy of our community resources to cope with these problems is also sadly underlined.

Abraham Leff, M.D.

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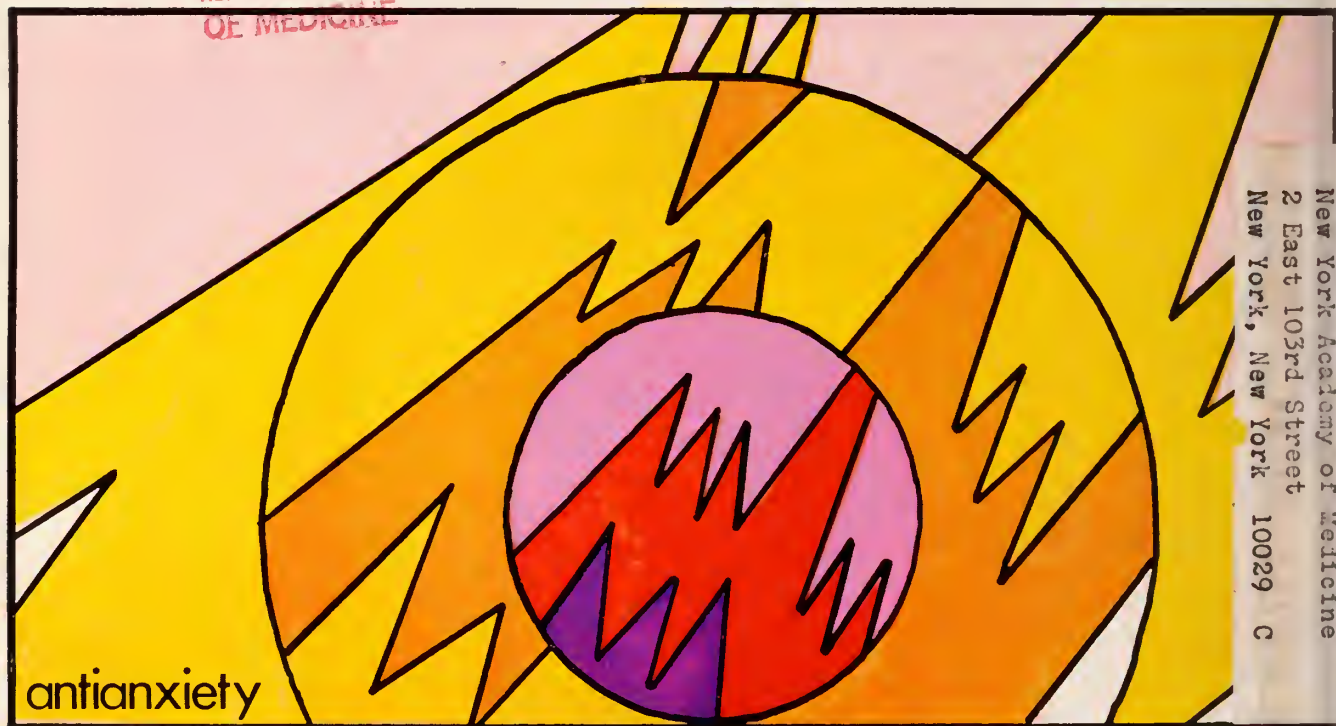
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ing depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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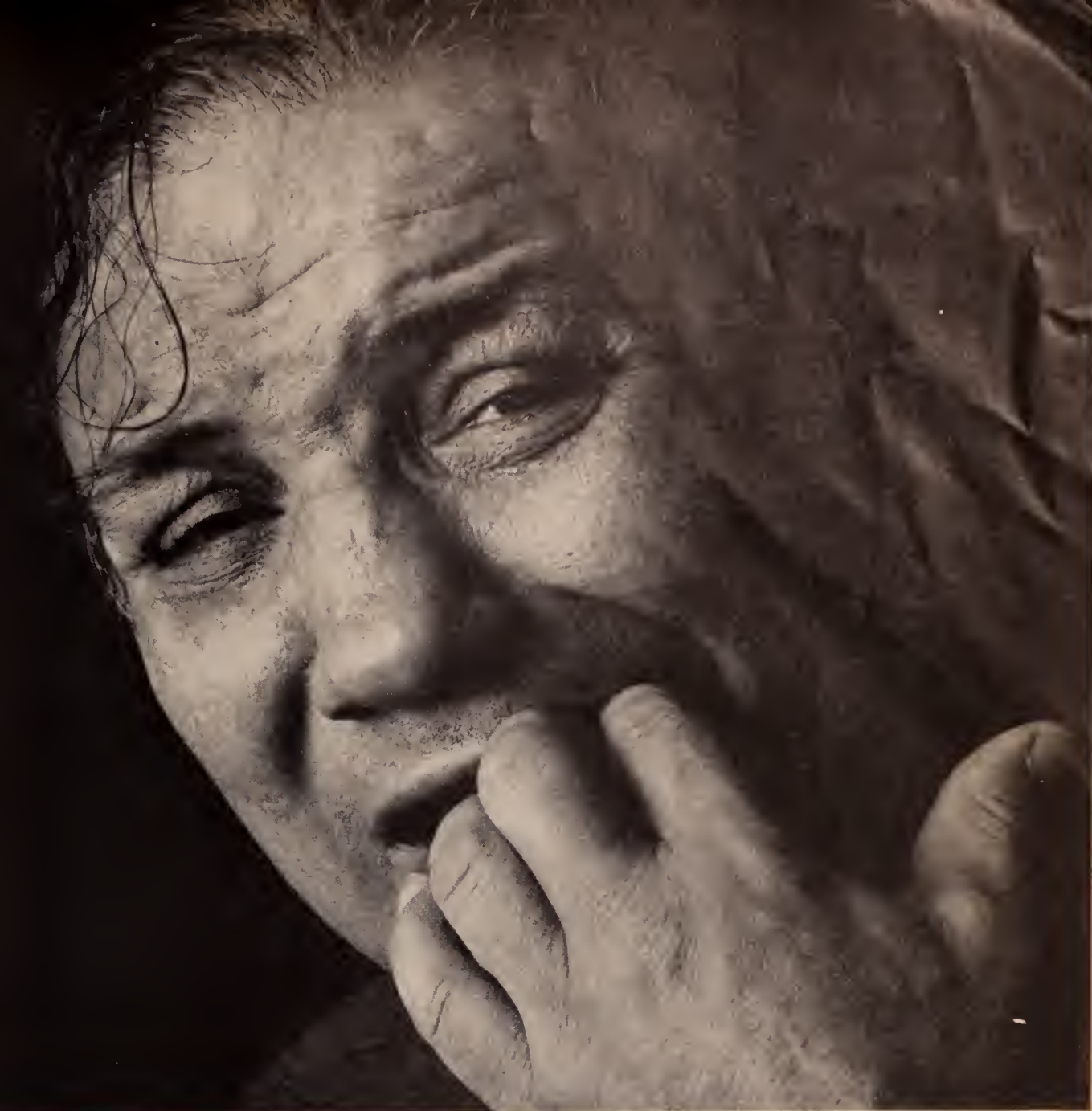
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EDITORIALS

Vote "Yes" on the Bond Issue

A referendum offers democracy in pure culture. We will have our day this November when you and I are given a chance to vote on a bond issue earmarked for "higher education." The lion's share of this is aimed directly at medical and dental education, though other educational needs (particularly teacher training) are not neglected. The factors which make an affirmative vote so necessary are detailed in the memorandum from Dr. Bergen on page 847 of this *Journal*.

It is seldom that this Society or its *Journal* comes out in support of an issue at the November elections. This, however, is one of the rare occasions where the issue can be put this simply. There either is or is not a future for medical-dental education in our state. And this is one way to show where we do stand. Dr. Bergen's memorandum cites the supporting figures which suggest that up to now health education in our state has not been batting in the big leagues. Here is our chance to move it in that direction.

Quacking Is Not Yet Stilled

"Physicians, as conservators of the public health, are bound to bear emphatic testimony against quackery in all its forms." So said the American Medical Association's Clinical Convention in Philadelphia in December. The year was 1847!

From its inception 124 years ago, the American Medical Association has been battling quackery and is dedicated to a continuation of this warfare against wasting the nation's health and its health care dollars . . . of fighting fraud at the bedside of ill and desperate people.

The health quack is not so easy to spot these days. The stovepipe hat and the pitchman's hawking have gone. In their place are their space-age counterparts, the suave, sophisticated super salesmen with smooth manners. These merchants of menace, more insidious and unscrupulous than ever, have many new products, diet fads, valueless food supplements, useless cosmetic devices and treatments, and worthless "cures" for everything—even into the area of brain-damaged children and mental illness.

They bilk the undiscerning, the uninformed, the desperate, and the unsuspecting of all ages. The estimates of the costs of medical quackery have been responsibly put as high as a billion dollars a year. One authority has stated that "medical quackery each year costs more lives than all crimes in the United States."

It is this cost of life—and health—that has placed America's physicians in the front lines of the war on quacks. It is the insidious side effect of quackery with which medicine concerns itself—the delay in proper medical care that may cost life itself. It is for this reason, too, that the medical profession is dedicated to education of the people about cultism, about any health sects that turn their backs on scientific medicine.

The House of Delegates of the American Medical Association said in 1933: "Either the theories and practices of scientific medicine are right and those of the cultists are wrong, or the theories and practices of the cultists are right and those of scientific medicine are wrong." And in 1961, it resolved that: "There can never be a majority party and a minority party in any science . . ."

After the quack or cultist has extracted his pound of flesh—after the damage is done and after the sick have become the dying because of delay of proper care—scientific medicine is called upon to pick up the pieces. Medicine has tried to do that job, too, but how much easier the job would have been—how many lives would have been saved—if . . .



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ORIGINAL ARTICLES

Here in a few pages is a useful manual of resuscitation.

Resuscitation in the Emergency Room*

James M. Blackwood, M.D./Newark

Successful resuscitation of the severely injured patient in the emergency room depends on the presence of knowledgeable personnel, the availability of properly maintained equipment, and a plan of organization.

Table I shows the injuries seen at the Martland Hospital Unit of the College of Medicine and Dentistry of New Jersey at Newark. Note the disproportionate number of crimes of violence. Hospitals near a busy freeway would expect to see more serious auto accidents. Regardless of the types of injuries, there are patients whose lives depend on what is done in the first few seconds or minutes in the emergency room.

Table I

	Per Week
Gunshot Wounds	6
Stab Wounds	15
Muggings	44
Serious Auto Accidents	1

A busy city hospital emergency room is called upon to resuscitate several patients each day. The problem becomes more acute at smaller hospitals where the emergency room coverage may be less than ideal, and where the professional personnel may not have surgical training. Actually the emergency room should be geared to provide basic and urgent lifesaving measures. After resuscitation, if the patient needs it, he is taken directly to the operating

room. If the nature of the injury so dictates, he is moved to the Intensive Care Unit where more sophisticated diagnostic and therapeutic technics can be tried. It is important for those who are only occasionally called upon to resuscitate patients to review these basic measures.

The first requirement is to establish adequate ventilation. Mouth to mouth ventilation is often effective, but rarely indicated in the emergency room. The oxygen concentration of expired air is adequate for resuscitation and carbon dioxide will not hurt the patient. The biggest disadvantage is that the resuscitator can do little else. Some patients have active tuberculosis, pneumonia, or have recently vomited, and it takes exceptional fortitude to give effective ventilation under these circumstances. Also, if the patient is ventilated at an adequate depth and rate, the resuscitator will soon find himself feeling dizzy or light-headed. We recommend ventilating bags with either a face mask and oral airway or an endotracheal tube. The choice between the face mask or the endotracheal tube usually depends on how obtunded the patient is. In general, if the patient can tolerate it, a cuffed endotracheal tube is better, as it greatly decreases the chance of aspirating gastric contents. Even the occasional resuscitator

*Read before the Section on Surgery, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1971.

should, therefore, learn to use the laryngoscope and to insert an endotracheal tube. A good practice is to intubate every DOA in the emergency room. Magill forceps are particularly useful for the relatively inexperienced intubator.

Some injuries present special ventilatory problems. A sucking wound of the chest should be closed with whatever material is available. If the wound has already been occluded, the dressing should not be disturbed until the patient is in the operating room ready for emergency thoracotomy. Flail chest should be treated with positive pressure ventilation, preferably with an endotracheal tube until a tracheostomy can be performed. Hemopneumothorax, if present, should be treated with intercostal drainage. In severe maxillofacial injuries a 13 gauge needle inserted through the cricothyroid membrane will let the patient breathe until tracheostomy can be done.

Cardiac arrest in trauma patients is usually associated with anoxia secondary to hemorrhage, aspiration, or inability to breathe for a variety of reasons. Patients with pre-existing heart disease may have arrhythmias and arrest with relatively minor trauma. If arrest is suspected, closed chest cardiac massage and ventilation should be started immediately, without waiting for electrocardiographic evidence of the arrest. Only 4 or 5 minutes are available before there is irreversible brain damage. It is almost impossible to feel peripheral pulses when closed chest cardiac massage is being tried. The effectiveness of the massage is best gauged by observing the pupils. They should contract within 45 seconds if the massage is effectively restoring circulation. Once effective circulation is re-established, the electrocardiographic leads can be attached and appropriate venous lines established.

Another therapeutic maneuver to be considered is the "chest thump." This is a forceful blow delivered to the pre-cordium by the fist. This will often revert ventricular tachycardia, ventricular fibrillation, and cause systole

during standstill. The fist can also be used as an external cardiac pacemaker in cases of heart block with standstill systole occurring with each blow of the fist.

After effective circulation is established by external massage, the electrocardiogram will usually show either ventricular fibrillation or standstill. In either case, "chest thump" should be tried at least once. The D. C. defibrillator should then be used if ventricular fibrillation persists. For standstill, 1 cc. of 1/10,000 epinephrine or 5 cc. of 10 per cent calcium chloride given intravenously will often start fibrillation, which can then be reverted with the D. C. defibrillator. Direct cardiac injection of these drugs is rarely indicated. Intravenous (particularly CVP) administration is just as effective and avoids the complications of myocardial laceration and pericardial tamponade. One ampule (about 40 meq) of sodium bicarbonate should be given intravenously for every 3 or 4 minutes that the patient is arrested. Lidocaine may be given if the heart is still irritable after being restarted.

The hypoxic heart cannot be restarted. The pupils should constrict within 45 seconds after effective closed chest massage begins. If they do not, the massage is not maintaining the circulation, and the various drugs and defibrillators will not work. The chest should then be opened. An incision is made in the fourth interspace anteriorly, below the breast. Bleeding will not be a problem. Don't worry about asepsis. Compress the heart about 90 times per minute, with the fingers behind. Do not open the pericardium, unless there is pericardial tamponade. A rib-spreader is helpful, but not essential. Once the chest is open positive pressure ventilation is necessary.

Gaining access to at least two major veins is necessary. Many products on the market facilitate percutaneous cannulation of veins. This may not be easy in patients in shock. Physicians working in emergency rooms should, therefore, know how to cut down on veins at any of the major sites (Table II).

Table II

Saphenous Vein at the Ankle
Cephalic Vein at the Wrist
Antecubital Vein
Cephalic Vein—Delto-Pectoral Groove
External Jugular Vein

Infusion lines should not be placed in the legs in cases of abdominal injury. Central venous pressure lines may be essential for later care, but may take too long to place to be effective in emergency resuscitation. CVP determinations may be misleading, if the catheter is kinked or located in the right ventricle, pulmonary artery, or coronary sinus. The position of the catheter should always be checked by x-ray, particularly if the pressures are not consistent with the clinical impression. There is danger with rapidly infusing large volumes of cold blood through a C. V. P. catheter. We do not recommend routing subclavian cannulation in trauma, although it does have some advantages. The incidence of pneumothorax or of hemopneumothorax with this procedure is not insignificant, particularly in the hands of those who

have not done several hundred.

Resuscitation equipment must be kept in a constant readiness. This implies a system of preventive maintenance. Laryngoscope bulbs and batteries must work. Ventilatory equipment must be clean and functional. Keeping the equipment in a box with a breakaway lock provides an effective maintenance system. Whenever the lock is broken, whether or not the equipment is used, the entire box is replaced by central supply. In central supply, the equipment is checked daily. Boxes are replaced on a rotational schedule even if not used. Electronic equipment presents a special problem. A survey of defibrillators showed that half were not working correctly, and that the watt-seconds actually delivered bore little resemblance to the meter indication. Many of these instruments are of shoddy workmanship, and it is not uncommon for instruments to be sold even if they have failed inspection. If a hospital does not have its own service group, definite contractual service arrangements should be made with the vendors before any equipment is purchased.

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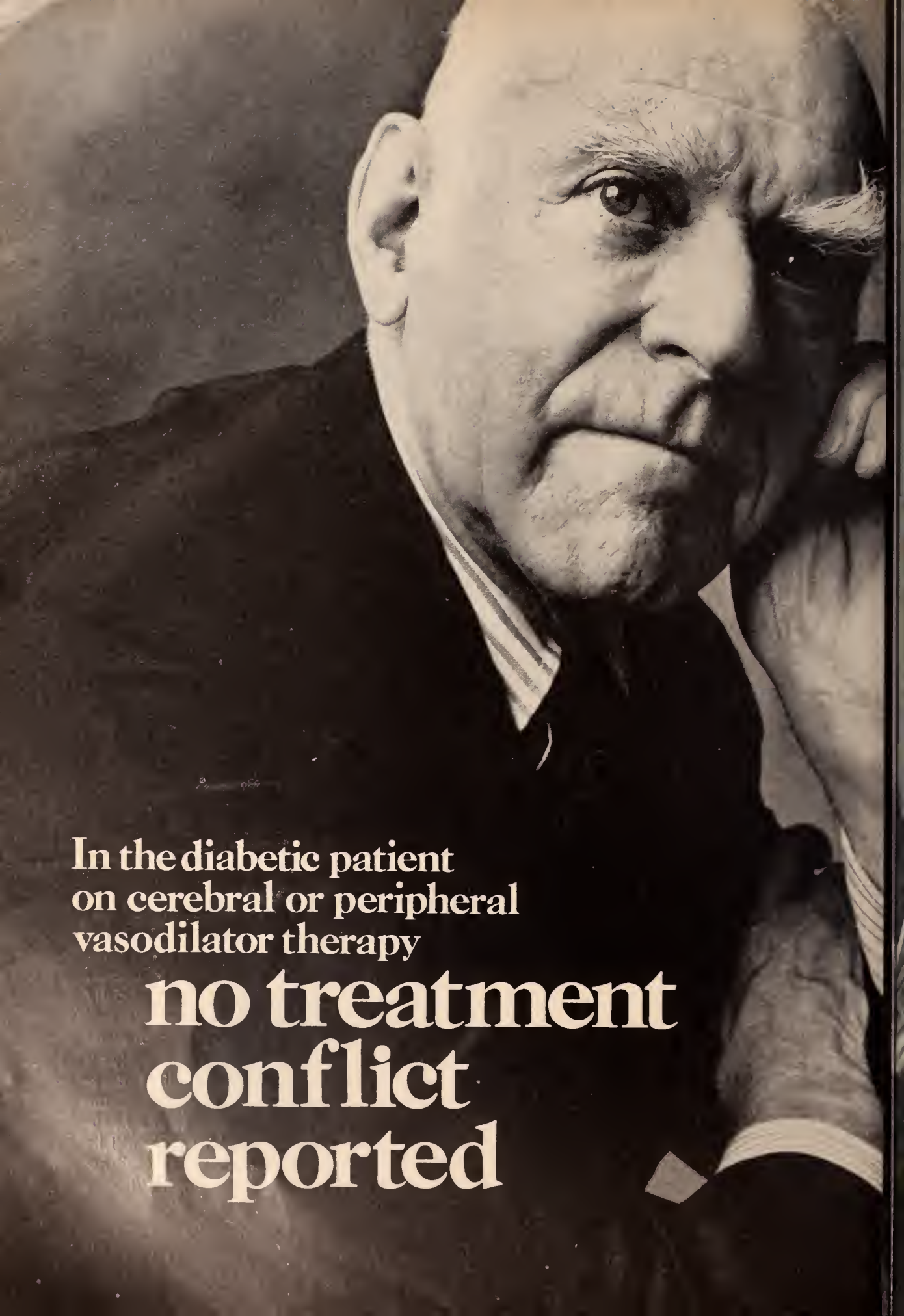
AMA Launches New Communications Program

The American Medical Association has initiated a special communication program in three national magazines and selected local media. Part of the effort will focus on better personal health care. Part will provide information on organized medicine's response to national health care issues. "The hope," explained Frank D. Campion, the AMA's Director of Communications, "is to make a positive, constructive contribution to people's own personal health and to the growing public dialogue on health care problems."

Plans call for eight full-page insertions in *Life*, the *Reader's Digest*, and *Ebony* during the remainder of 1971, possibly ten insertions in major newspapers, plus very limited exposure on television in a few cities. The budget currently provides for the expendi-

ture of \$750,000 in 1971 and a similar amount in 1972.

"One thing we are trying to accomplish," says the AMA, "is to remind everyone of a factor that is frequently overlooked—that the American doctor is a man, or woman, who cares deeply about people's health. It's important, for example, that we tell people, especially young people, that doctors share their concern over clean air and water. Nor do many people know that the AMA is very firmly on record in favor of expanding medical education. By emphasizing the many things the AMA is for, we hope to create a more receptive climate, a climate in which there will be a better understanding of organized medicine and its ideas for improving our health care system."



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Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators²⁻⁴ have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement^{2,5} and observation of clinical improvement. Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitis conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODILAN tablets, isoxsuprine HCl 10 mg and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Caution: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional precipitation and dizziness can usually be controlled by dosage reduction. Complete data available in product brochure from Mead Johnson Laboratories. References: (1) Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. 54:1021-1023 (July) 1961. (2) Clarkson, I. S., and LePere, D. M.: Angiology 11:190-192 (June) 1960. (3) Horton, G. E., and Johnson, P. C., Jr.: Angiology 15:70-74 (Feb.) 1964. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. 4:124-128 (April) 1962. (5) Whittier, J. R.: Angiology 15:82-87 (Feb.) 1964.

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In all the world's literature fewer than 40 cases of Sotos' Syndrome have been reported. Here are two additional cases.

Sotos' Syndrome*

Hypertelorism, Antimongoloid Slant of Eye,
And High Arched Palate Complex

**Manuel M. Villaverde, M.D. and
Jacyntho A. Da Silva, M.D./Woodbridge**

A syndrome characterized by accelerated growth during infancy, hypertelorism, antimongoloid slant of eyes, high arched palate, large mentum, and elongated hands and feet was described by Sotos¹ under the name of "cerebral gigantism." The name is not totally accurate, and should be replaced by the eponym "Sotos' syndrome"² or by a more descriptive one such as dysopstomauxesia (Ops, eye; Stoma, mouth; Auxesis, growth). Eye-mouth-growth (oculo-buco-crescent) syndrome may also be a workable name.

There is a remarkable likeness of these patients among one another. Most of them also show neurologic symptoms with more or less marked mental retardation. Fewer than 40 cases, most of them males, have been reported in all the world's literature.^{3,4,5,6}

Hook⁷ and Wiedman⁸ believe that these cases represent different clinical entities which should be included into a complex category of diencephalic syndromes. Here we suggest a wider category to include a few syndromes that show similar symptomatic appearance.

Two patients are described below. Here practically all the traits of the syndrome are present. In neither is the family history informative.

Case One

An Rh negative mother had a mild infection of the kidney during the third month of pregnancy, and a non-serious car accident the sixth. There is no record of her having been exposed to irradiation or noxious

medication during her kidney infection. After a full term pregnancy, labor was induced. The new-born weighed 9 pounds and 4 ounces and seemed healthy, though he was jaundiced, according to parents' report. There is no record of trauma, cyanosis, or respiratory distress. A congenital interventricular defect was diagnosed. But a recent examination by a cardiologist (Dr. Antillion) states that the rough long ejection systolic murmur (better heard at the upper left sternum border, with no diastolic murmur) and the electrographs make the most likely diagnosis the existence of an auricular septal defect, asymptomatic at the present time.

During his first year, he seemed to be a relatively healthy child. His parents said he was "flaccid," unable to sit even with aid. He also appeared lethargic, and only able to repeat words. It now seems probable that his entire development was retarded, excepting for growth: at three years of age he was 39½ inches tall (90 percentile for age) and his weight was 44 pounds. This is at the 50th percentile for age five. He had frequent pneumonitis, and had convulsions during febrile periods. Due probably to the internal rotation of the left foot, his gait was unsteady. He is allergic to codeine.

At three years of age, the Binet I.Q. was 56. His head was elongated. He showed hypertelorism, hyperactivity, and poor coordination.

Presently he is 9 years old, his height is 52¼ inches. This is between 25 to 50 percentile for age. His weight is 60, which is about 25 percentile for age. His large head is dolichocephalic in shape, with a circumference of 22½ inches. The skull shows thin bones, a relatively small base and a large sella turcica, all within reasonable limits. The chin is prognathic, the eyes are widely set apart (hypertelorism) and show antimongoloid slant, the hard palate is deeply arched (ojival palate), and the hands and feet are delicately elongated. His Binet I.Q. is 56. On the Columbia Mental Maturity Scale, he scores a mental age of 3.8. Leiter International Performance I.Q. is 62. On the Vineland Social Maturity Scale, the S.Q. is only 49. Medical examination is within acceptable limits. He has a systolic murmur at the upper left of sternum. The heart is somewhat enlarged as seen in x-ray plates. Extremities are adequately developed but somewhat elongated. The electro-encephalogram was suggestive of a right anterior temporal focus. Chromosomal karyotype was essentially non-contributory.

Case Two

After a full term pregnancy and 3 hours' labor, an apparently normal baby was delivered by low forceps.

* From the Woodbridge State School

Weight was 6 pounds and 9½ ounces. Retardation was first noticed in the sixth month because his development was slow except for growth. By the age of 4 years, he was 46½ inches tall (about 50 percentile for age 6 years) and his weight was at about the 50 percentile. His I.Q. was 46. A mild internal strabismus was noted on the left eye, with impaired vision. He had onychogryphosis of the right great toe.

At this writing he is 13 years 7 months of age; he is 57¼ inches tall (about the 50 percentile), and his weight, 89 pounds, is at the 25 percentile. His large head, (circumference 21½ inches) is slightly asymmetric and of the dolichocephalic type. The antimongoloid slant of the eyes is more apparent than the hypertelorism. The slight internal strabismus persists. There is a high arched palate. He has a mildly marked funnel chest. The EEG is normal. Recent mental evaluation shows a S.Q. of 67 on the Vineland Social Maturity Scale. Stanford-Binet I.Q. is 48.

The physical examination was within adequate normal limits for this left-handed patient. The routine laboratory tests were within reasonable limits. The skull was within normal limits, but also as with the first case, the bones are thin, the base somewhat small and the sella close to the largest normal size. The chromosomal studies appeared within normal limits.

Our patients resemble each other more than siblings do among themselves. A large dolichocephalic head is characteristic, and it is present in both cases. The eyes show the two traits, hypertelorism and antimongoloid slanting. The eyes seem to be sunken because of the general aspect of the face. A high arched palate and some enlargement of the chin are found in Sotos' syndrome and in our patients. Children with the syndrome are large at birth and grow rapidly during the earlier years of life, the majority being of average height at maturity. Some are tall, and there is the record of a giant. Bone age is usually advanced; hands and feet remain large; some patients show congenital abnormalities, such as short and tapered fingers and toes¹⁶ and syndactyly.¹⁷ One of our patients presents an interauricular septal defect, and the other a slightly marked funnel chest.

Most cases show mild to moderate mental retardation, 70 or over for the first three cases reported by Sotos.¹ A few are of normal intelligence. One of our patients showed a mild retardation (I.Q. 56); and the other, a moderate retardation (I.Q. 48). Neurologic manifestations vary widely, particularly incoordination, clumsiness, and also ataxia. Stephenson's patients¹⁵ had partial resolving hemiplegia and seizures. In Ott's case¹⁹ there were no seizures, but the electroencephalo-

gram corresponds to epileptic patterns. Our first patient presented convulsions during febrile periods, and his EEG was suggestive of a right anterior temporal focus. The EEG of the second patient was normal.

Radiologically, dilated ventricles have been found on pneumo-encephalograms of many patients,¹ but not all.^{8,16} Other patients only showed borderline, if not entirely normal pneumoencephalograms. The sella turcica was at the upper limits of normal, with a marked inclined posterior dorsum in about half of the cases.⁸ In our two patients, radiographs resembled those presented by Poznanski;⁸ the skull bones were thin, the mass of bone at its base was small, and the sellae relatively large but within normal limits. There is usually an accelerated bone ossification,¹⁸ the sutures being somewhat widened⁸ in almost all patients.

Diagnosis is based upon rapid growth in early infancy and the peculiar appearance of head and face.⁷ In pure gigantism growth persists after infancy, and the head is brachycephalic. Other clinical entities also showing the same triad (hypertelorism, antimongoloid slant of eyes, and high arched palate) should be excluded. In pure hypertelorism antimongoloid slanting of eyes may be absent; the greater wings of the sphenoid are poorly developed and the lesser may be overdeveloped; it is frequently found together with multiple congenital defects, but rarely accompanied with severe symptomatology. In the De Lange's syndrome⁹ there is microcephaly, micromelia, and retarded growth, together with many different anomalies (over 125 recorded) and no consistent chromosomal abnormality. In the cerebro-hepato-renal syndrome the similar pattern of multiple congenital anomalies suggests¹⁰ a common etiology. One patient was born with a general development close to the upper normal limits.

The triad also is found in chondrodystrophia calcificans congenita, in which the head is mainly brachycephalic, and there is shortening of the proximal long bones¹¹ in the "cat-cry" syndrome, with microcephaly and dele-

tion of the arm^{12,13} of chromosome 5; the Rubinstein-Taybi syndrome, with broad thumbs and great toes¹⁴; and the oral-facial-digital syndrome.¹⁵

Hook and Reynolds⁷ concurred with Sotos in not finding evidence of genetic factors. Kowlessar²⁰ presented the first instance of familial occurrence, confirmed by Hooft *et al.*¹⁷ An autosomal recessive inheritance is, perhaps, suggested. No chromosomal abnormalities are reported. Our two patients did not reveal significant deviation of the karyotype.

Growth hormone levels in blood were found normal, and also within normal limits were insulin assays during glucose tolerance test, adrenocortical responsiveness, PBI, and other endocrine functions.⁷ But Milunsky *et al.*¹⁶ found a failure to increase growth hormone levels during hypoglycemia, thus believing some developmental defect could occur during embryogenesis affecting the hormone release mechanism of growth. Of course, the acromegalic traits suggested by Sotos¹ and accepted by others²² do not correspond to true acromegaly, in which the mandible is heavier, hands and feet are thicker, and all traits are coarse instead of delicate as it happens with dysostomauxesia patients. A history of anoxia is found in more than a half of the patients (not in our patients), possibly due to the large head.²³ McMahon's²² first case was delivered by cesarean section.

The triad hypertelorism, antimongoloid slant of the eyes, and high arched palate is not rare among strictly normal people. It is also found among carriers of several different and even unrelated pathologic syndromes. On the other hand, certain developmental anomalies may occur either isolated or integrated as part of a more or less conspicuous part of a more complex syndrome, like epicanthi found among normal beings as well as those with mongolism, Turner's syndrome and many other diseases or syndromes. Certain aggregates of minor anomalies may appear together as a part of more complex clinical pictures, as if forming sub-syndromic groups of some individuality. Comings²⁴ states that cases like the "clover leaf (*Kleeblattschadel*) syndrome" may associate with or show some resemblance to other different abnormalities, such as chondrodystrophy, acrocephaly and even achondroplasia. That is what happens with the triad hypertelorism, antimongoloid slant of the eyes, and high arched palate, which is present not only in Sotos' syndrome but also in Apert's disease, Crouzon disease, De Lange's syndrome, ring chromosome 18, and in Greig's hypertelorism. Furthermore, these sub-syndromic aggregates may break into partial pictures (for

instance, patients with the Lawrence-Moon-Biedl syndrome may present all the symptoms, or only retinitis pigmentosa or polydactyly). There are patients who only show hypertelorism and antimongoloid slant of eyes, with normal palate ("cat-cry" syndrome, *Kleeblattschadel* syndrome, median cleft face, hypercalcemia, and oto-palate-digital syndrome); or hypertelorism with high arched palate and normal slant of eyes (Hurler's syndrome, cerebro-hepato-renal syndrome, and chondro-dystrophia calcificans congenita); or antimongoloid slant of eyes, high arched palate and no hypertelorism (Turner's syndrome—some cases may present hypertelorism—Rubinstein's syndrome, and Treacher-Collin's syndrome). Back in 1943, we wrote, a "relationship among anomalies is most probable to exist"²⁵, because of the extremely frequent finding of multiple and different anomalies on patients affected with similar syndromes but who do not show exactly the same symptomatology—recall the 125 anomalies found among patients with the De Lang's syndrome.

What we want to stress is that the triad hypertelorism, antimongoloid slant of the eyes, and high arched palate, as found in patients who grow fast, may be only a part of a more important physiopathogenic clinical complex or entity. More than 60 years ago, Babés²⁶ called our attention to the fact that congenital anomalies affecting the head do determine an abnormality of all four limbs, on the assumed basis that on its basilar area there is a center governing their morphology. Cushing²⁷ agreed that hand structure is deeply modified by pituitary disorders. Generally speaking, we²⁵ found that congenital anomalies are frequently associated with endocrinopathies, particularly those with some involvement of the hypophyso-hypothalamic area. Weideman *et al.*⁸ want to include most of them into a complex category of diencephalic syndromes.

The triad hypertelorism, antimongoloid slant of the eyes, and high arched palate may be found in normal people as well as in patients presenting more or less defined clinical pictures. Perhaps the most common accompanying derangement is an abnormal growth—defective in most instances, excessive only in Sotos' syndrome and in Marfan's syndrome (not all the components of the triad appear in all patients in the latter syndrome).

The head is most frequently small and brachycephalic among patients showing the triad, but may be large and dolichocephalic. Other abnormalities may also be found (cardiovascular, hepatic, renal, but mostly skeletal). In other words, anomalies other than the

basic for a particular syndrome may be found in each individual patient.

The same cause may provoke different anomalies (rubella provoking abnormalities of the eyes or of the circulatory system) or the same anomaly may be produced by different causes (circulatory defects provoked by rubella or thalidomide). When the head assumes dolichocephalic proportions, particularly following premature closure of sutures, the base of the skull is often hypoplastic, the greater wings of the sphenoid are ordinarily underdeveloped and the maxillae are generally small, high arched or even fissured (cleft palate). All these facts confirm Sotos' statement¹ that the causative factor of dysopstomauksia should be found in the hypothalamus or any other brain region capable of modifying the natural growth-timing mechanism. Better to say the developmental mechanism, because abnormal growth is not all to be explained in Sotos' syndrome. Babson²⁸ found that 23 per cent of oversized children (against 10 per cent in the average) have I.Q.'s below 80. Other anomalies also count, and their causative factor may also be ascribed to the hypophyso-hypothalamic region,²⁵ because some abnormal or subnormal development of the skull

apparently is a part of the complete symptomatic feature.

Those who are mentally retarded, with upper level I.Q.'s (like the majority of the mentally retarded) are good candidates for special training and education. Care should be taken that they receive medical supervision together with educational and social treatment. Seizures, when present, do respond to anticonvulsant therapy. Prevention of gigantism may be carried on on selected cases, though the risk of this is small.

Summary

Two patients presenting Sotos' Syndrome are discussed. The major components of the syndrome are accelerated growth during infancy together with hypertelorism, antimongoloid slant of the eyes, high arched palate, and large mentum. The triad of hypertelorism, high arched palate, and antimongoloid slant of the eyes appears to be a sub-syndromic complex also present in many other syndromes, suggestive of an involvement of the hypothalamic region of the brain.

A bibliography of 28 citations appears in the authors' reprints

Woodbridge State School Hospital

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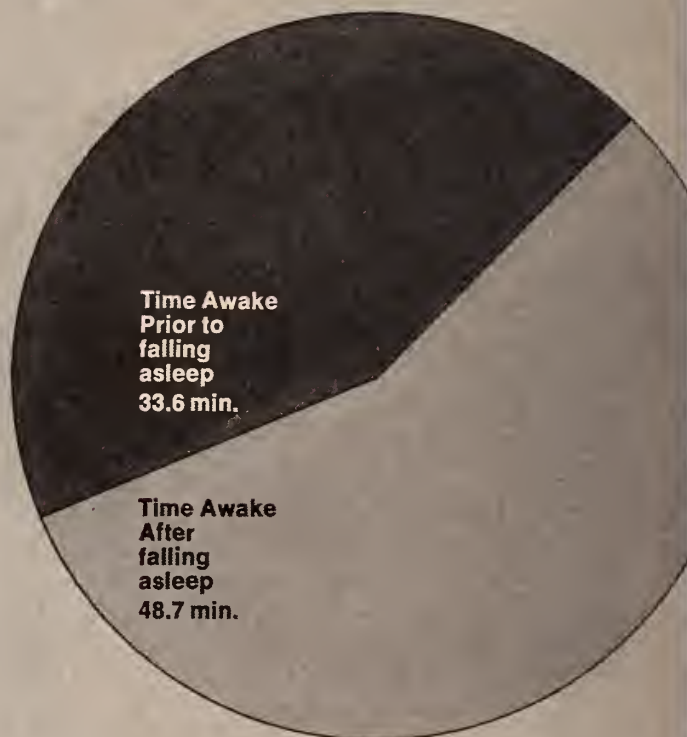
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References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

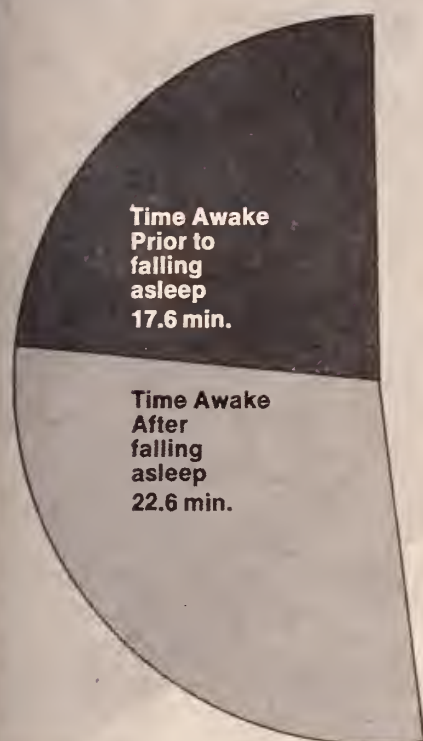
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

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asleep
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**Time Awake
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asleep
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Average sleep laboratory measurements in cited studies

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Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Bladder Dysfunction Complicating the Management of Diabetes

Jay A. Cohen, M.D. and
Emanuel Abraham, M.D./Asbury Park*

It is customary to gauge insulin dose by urine sugar measurements. Here reported is a patient in whom incomplete bladder emptying led to the persistence of urine sugar after diabetic control was achieved. This is a dramatic example of the danger of this practice. Unfortunately, the situation is not rare. Inaccurate diabetic urines may actually be common when insulin dose is being regulated. It is suggested that blood glucose be used where possible as a guide to insulin therapy.

A 69 year old female complained of weakness and poor appetite. She had never been presumed to have diabetes. For three weeks she had polyuria and polydipsia and for two weeks she had anorexia and a sore mouth. She had frequent urination, occasional difficulty in voiding and had been incontinent for an unknown length of time. A twin sister had diabetes, requiring insulin for fifteen years. A brother had mild diabetes. Three years prior to this event, she had a cerebral thrombosis with transient hemiplegia. For two years she had been on antihypertensive medication.

Her pulse was 108 and blood pressure was 150/80. Her tongue was red and parched. There was a grade 2/6 systolic murmur at the second right intercostal space. Deep tendon reflexes were all active and equal bilaterally, but she had a positive right Babinski. Pertinent laboratory data included: normal urine sediment; WBC, 12,300 and Hgb, 16.9 Grams per 100 milliliters on admission; blood sugar, 600 milligram per 100 milliliters on admission; BUN, 25 milligrams per 100 milliliters; serum sodium 128, chloride 93, potassium 3.5, and bicarbonate 24 milliequivalents per liter; serum acetone negative; serology negative; urine cultures had no growth. An intravenous pyelogram was normal.

Urologic studies revealed a 50 milliliter residual urine (normal residual is 0). Bladder capacity was 600 milliliter (normal is less than 500). Cystogram indicated incomplete emptying and a hypotonic bladder.

The patient was treated at first with regular insulin

and hypotonic electrolyte solutions. The urine and blood sugars during the initial phase of treatment are shown in the table. While blood glucose became normal and almost hypoglycemic, urine sugar remained four-plus. When confronted with the disparity we initially trusted the urine measurements rather than the blood tests.

Date	Time	Urine Sugar	Urine Acetone	Blood Sugar
First Day	5:15 pm	4+	1+	600
	6:15 pm	4+	1+	
	8:15 pm	4+	1+	92
	10:00 pm	4+	1+	65
Second Day	12:00 mn	2+	Neg	70
	2:00 am	3+	Neg	
	4:00 am	3+	Neg	
	6:00 am	3+	Neg	
	8:00 am	2+	Neg	
Fourth Day	7:00 am	Neg	Neg	
	8:30 pm			230

This patient's urine measured four-plus sugar and one-plus acetone, while her blood sugars were actually low normal. Subsequent glucose-free urines indicate that abnormal tubular function did *not* cause the sugar to spill into the urine. It seems, therefore, that the glycosuria represented previously formed urine. The delay in elimination of the urine could be explained by abnormal bladder emptying. Urologic investigation¹ revealed the characteristic abnormalities seen in diabetics.² It has long been known that diabetics may have atonic ("neurogenic") bladders. The incidence was thought to be very low until a controlled study on thirty unselected young diabetics by Fagerberg *et al.*¹ revealed that 65 per cent had bladder disturbance of some kind and 33 per

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cent had urinary retention. Formerly, this abnormal diabetic bladder function was attributed to neuropathy, especially disease of the posterior columns. Our patient showed normal vibration sense and position sense, and no neurologic evidence of any lesions of the posterior columns. Most diabetics with neuropathy, do have bladder dysfunction,² but many have hypotonic bladders without neuropathy. Here the cause of the diabetic bladder is uncertain.

Clinically the diabetic bladder may be asymptomatic² at first. Later there is an increased interval between voiding, with straining, hesitation, and weakness of stream. With the onset of residual urine, infections become common. There is no relationship³ between the development of bladder dysfunction and sex, severity of diabetes, or mode of treatment. The habit of pressing on the lower abdomen to void⁴ is a clue to this disorder.

The incidence of abnormal bladder emptying which could lead to false glycosuria is probably even higher than Fagerberg *et al.*¹ reported. Fagerberg studied young diabetics¹ and it is suspected³ that the diabetic bladder becomes more common with increasing age, for in the elderly diabetic male population, prostatic obstruction with urinary retention occurs. Normal bladders often empty poorly after abdominal and pelvic surgery and at times of stress, and at these times the diabetic bladder probably gets worse.³

The role of bladder dysfunction as a cause of papillary necrosis is unknown but deserves study. Similarly, the possibility that a diabetic bladder is a factor in hyperosmotic, non-ketogenic coma is intriguing. When thirst is impaired, urinary tract obstruction can lead to hemoconcentration⁵ because the obstruction damages the concentrating mechanism.

This patient's identical twin has diabetes. The concordance of diabetes in identical twins⁶ is 48 per cent.

Summary

An uncontrolled diabetic continued to have strongly positive tests of urine sugar even after blood glucose approached hypoglycemia. She was found to have a hypotonic bladder with urinary retention. Bladder abnormalities in diabetics are a common but unpublicized cause of inaccurate glucose measurements.

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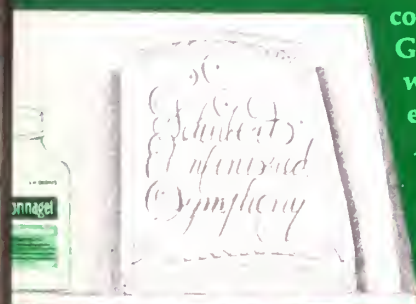
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Non-narcotic for 6-8 hr. cough control

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ROBITUSSIN A-C®					
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COUGH CALMERS®					

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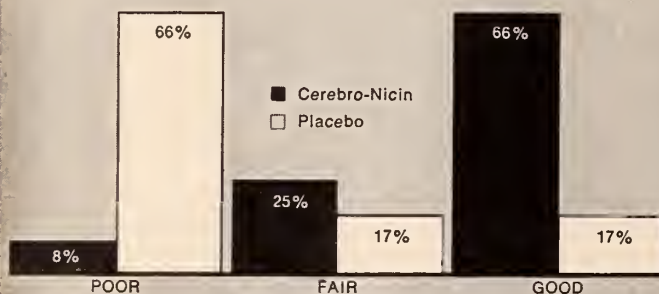
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jnl., of the Amer. Ger. Soc. June, 1964

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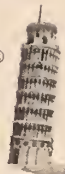
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Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema. Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montanano, P. and Evangelista, I. Methyltestosterone-thyroid treatment of actual impotence. Clin. Med. 12:69, 1966. 2. Rubin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West. Med. 5:61, 1964. 3. Tietz, A. S. Methyltestosterone-thyroid in treating impotence. Can. Prac. 25:6, 1962. 4. Hallman, L., Bradlow, H. L., Zimet, B., Takashima, D. K., and Gallagher, T. F. Thyroid-androgen interactions and the hypohypothalamic effect of androstanoes. J. Clin. Endocr. 18:136, 1959. 5. Farris, E. J., and Cullen, S. W. Effects of L-thyroxine and rothyronine on spermatogenesis. J. Urol. 79:853, 1958. 6. Oval, K., and Farrar, G. E. United States Pharmacopoeia (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Werhuf, L. F. Sexual impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Radiotherapy with adjuvant chemotherapy are found to be helpful modalities in treating non-resectable ovarian cancer.

Radiotherapy of Ovarian Carcinoma*

Louis J. Sanfilippo, M.D./Livingston

Surgery is universally recognized as the cornerstone of treatment of ovarian carcinoma. Most patients, however, are too advanced for total surgical removal. Radiotherapy is an adjunct to surgery both for palliation and for cure. But opinions vary as to indications, techniques' tolerance, and results of treatment. In the past, results have been difficult to interpret because of lack of uniformity in clinical staging methods, histologic description, surgical procedures, and radiotherapeutic methods. It is also difficult to separate the natural history of the disease from the effects of its treatment. Evaluation must take into account prognostic factors. The major ones are: (1) the anatomic extent of disease (at laparotomy), (2) the histologic tumor type, and (3) its degree of differentiation.

Clinical Staging

A review of four large series^{1, 2, 3, 12} reported with use of the International Staging System (F.I.G.O.)¹² reveals excellent correlation between clinical stage and 5 year survival. (Stage I is defined as disease limited to the ovaries; Stage II with pelvic extension; State III with spread to the abdomen; and Stage IV with spread to distant sites outside the peritoneal cavity—see Table 1) Survival rates were: Stage I, 60 to 70 per cent, Stage II, 29 to 43 per cent; Stage III, 3 to 18 per cent; and Stage IV, 0 to 12 per cent. Incidence of cases in Stage I ranged from 14 to 35 per cent. In all series, the majority had spread to the pelvis or beyond, (Stages IIB-IV).

Table 1
*Carcinomata of the Ovary—
Correlation of Anatomical Extent and 5-Year Survival*

INSTITUTION	# CASES	STAGE*			
		I	II	III	IV
M. D. Anderson Hosp., Houston	863**	65.1%	39%	18.5%	11.9%
Radium Hemmet Stockholm	555	60.0%	42%	3.6%	0 %
Western Inf. Glasgow	372***	70.0%	43%	14.4%	1.4%
Norw. Radium Hosp & Norsk Hydro's Inst., Oslo	829	63.0%	29%	12.0%	6.0%

*International classification (F.I.G.O.)

**Includes approx. 13% non epithelial malignancies

***Includes approx. 5% non epithelial malignancies

Histologic Classification

An international histologic classification (F.I.G.O.)²¹ of common epithelial carcinomata has also been recommended. Four main groups are designated: (1) mucinous, (2) serous, (3) endometrioid, and (4) unclassified. The correlation of cell type with five year survival is more variable than that seen with clinical staging—see Table 2. The mucinous and endometrioid carcinomata appear to have a better prognosis than the serous and unclassified types. Five year survival rates ranged from 36 to 63 per cent for the mucinous, 21 to 55 per cent for endometrioid; but were only 15 to 29 per cent for the serous carcinomata. The incidence of mucinous tumors varied from 9 to 18 per cent; the serous from 34 to 50 per cent; the endometrioid from 25 to 30

*Read before the Section of Obstetrics and Gynecology, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 16, 1971

Table 2
*Epithelial Carcinomata of the Ovary—
 Correlation of Histological Type and Survival*
 Type—5 Year Survival

INSTITUTION	#CASES	MUCINOUS	SEROUS	ENDOMETRIOID	UNCLASSIFIED	TOTAL
Radium Hemmet Stockholm 1968	555	62.7%	14.8%	55.4%	21.7%	32.3%
Western Inf. Glasgow 1970	420	36.0%	22.0%	21.0%	53.0%*	27.0%
Norw. Radium Hosp Norsk Hydro's Inst., Oslo 1971	829**	42.0%	29.0%	43.0%	18.0%***	33.4%

* 14/38 cases in unclassified group are dysgerminoma and granulosa cell Ca.

** Total group includes 63 cases of mesonephroid Ca with 44.5% survival.

*** Undifferentiated Ca's only.

per cent; and the unclassified from 9 to 19 per cent.

Histologic Grading

The histologic grade of a tumor has an influence on survival and is interrelated with clinical stage.^{15, 19} Dalley⁴ reviewed 371 cases of serous and mucinous carcinomata classified into well differentiated and poorly differentiated (or anaplastic) types. Survivals at 3, 5, and 10 years were 50, 39, and 33 per cent respectively for the well differentiated; and 24, 14, and 12 per cent for the poorly differentiated group. In each stage, survival was better for low grade lesions. The proportion of high grade lesions was higher in advanced stages. Munnell¹⁹ divided serous carcinomata into three histologic grades and found a similar correlation.

Pathways of Spread

Ovarian carcinoma commonly spreads in three ways: (1) by direct extension to adjacent organs; (2) to lymphatics of the para-aortic chain; and (3) to peritoneal surfaces.¹⁴ Spread by transplantation, particularly in serous carcinoma, may occur early in the disease. Surprisingly, malignant cells have been found in the peritoneal fluid after complete removal of tumors limited to one ovary.

Surgery

With rare exception, completely resectable disease is treated by total abdominal hysterectomy and bilateral oophorectomy.^{2, 15} Many authorities⁶ also recommend this procedure in

more advanced disease,⁹ including removal of as much metastatic disease as is feasible. Others say that resection of fixed masses spreads the cancer¹³ and hastens recurrence and recommend pre-operative irradiation instead.¹⁴

Radiotherapy

Post-operative irradiation has been employed in all stages. There is disagreement as to whether it is indicated in Stage I, especially Ia (limited to one ovary). Advocates point out that even with total excision of disease, the peritoneal cavity is potentially contaminated by free floating tumor cells.^{6, 9, 10, 17} However, irradiation should certainly be offered in Stages II and III because microscopic or gross residual carcinoma is inevitably present. Chemotherapy may precede (or be given concurrently with) irradiation in advanced disease with large masses or massive ascites. Stage IV cases or those with extensive involvement of the upper abdomen, or with liver metastases should receive chemotherapy.

Technics depend on the anatomic extent of disease at surgery, the amount of residual carcinoma, the tumor type, and the tolerance of the irradiated volume.

Pelvic irradiation is generally recommended for disease grossly limited to the pelvis, completely or incompletely removed (Stages I & II). Whole abdominal irradiation is necessary for State III lesions and may be advisable for Stage IIB disease especially serous carcinomata. Limiting factors in abdomino-pelvic

irradiation are the radiosensitivity of the liver, kidneys, gastrointestinal tract, and hematopoietic systems.^{6, 8, 24}

The dose to the liver and kidneys should be reduced to tolerance levels by appropriate shielding. Gastrointestinal reactions can usually be managed medically. If they are severe, however, treatment may have to be interrupted temporarily. Serial blood counts are mandatory. Leukocyte count should not be allowed to fall below 2000, nor the platelet count below 50,000.

Since most ovarian carcinomata are of limited sensitivity, the dose administered is given to the limit of tolerance except for dysgerminomas and granulosa cell carcinomata. In these cases¹⁵ doses of 2000 to 4000 rads are adequate.^{12, 16}

Irradiation of the pelvis with megavoltage energy of 5000 rads in five weeks is usually well tolerated. If the lower abdomen (to the umbilicus) is included, the dose rate should be reduced. Doses to this larger volume of 4500 to 5000 rads in 6 to 6.5 weeks can be given safely. Two methods are commonly used for irradiation of the abdomino-pelvic cavity: (1) open opposing ports;^{8, 21} and (2) moving strip irradiation.⁶

With open ports, one should aim for 3000 rads in 4 to 5 weeks. The tumor dose for the 2.5 cm moving strip technic is 2500 rads in 8 fractions in 10 to 12 days. This is the biologic equivalent of 3400 rads given in 25 fractions in 5 weeks.⁷ Local and systemic tolerance appears improved compared with the open port method, although no superiority in results has been demonstrated.

Recently, a more rapid, less intense 4 centimeters moving strip method has been developed, shortening the over-all treatment time by two weeks (to treat from pelvic floor to diaphragm).²⁰ The tumor dose is 2000 rads in six fractions in eight days. Its biologic equivalent is approximately 3000 rads given over a five week period.⁷

Supplemental pelvic irradiation of 1000 to 2000 rads is standard after both open port and moving strip irradiation and is well tolerated.

Radioisotopes

Both radioactive colloidal gold (Au^{198}) and colloidal chromic phosphate (P^{32}) have been used intraperitoneally^{9, 17} for serosal irradiation.^{10, 18} Au^{198} had 90 per cent beta irradiation, and P^{32} , 100 per cent. Since the range of beta rays is a very few millimeters, radioisotopes are of most value for potential tumor cell contamination of the peritoneal cavity, or when minute serosal seedings are present. Isotopes have been used to control ascites in the past with variable success, but they now have been replaced by alkylating agents given systemically.^{3, 10, 18}

Chemotherapy and Radiotherapy

Theoretical and experimental evidence suggests that certain chemotherapeutic agents may sensitize cells to irradiation and thereby potentiate its effects.²³ These drugs produce modification of the DNA molecule which is the prime target of ionizing radiation. Kottmeier¹¹ compared two large groups of inoperable carcinomata and achieved 47 per cent sustained palliation with irradiation alone, compared with 87 per cent treated by irradiation and Thiotepa.⁶

Decker⁵ found that far advanced carcinomata treated with surgery, irradiation, and cytoxan responded much better than those treated with surgery and irradiation alone. Mean survival time was prolonged and the response rate was higher. Chemotherapy, intraperitoneally and systemically, also appeared to enhance results when combined with complete surgery and radiotherapy, compared with complete surgery and radiotherapy alone. The 5 year survival for Stages I-III (excluding Ia) was 60 per cent for those receiving chemotherapy, and 47 per cent for those who did not.²⁴

The prime difficulty with adjuvant chemotherapy is hematopoietic depression, especially

with whole abdominal irradiation. Temporary interruption of treatment is often necessary to permit blood elements to recover.

Cytosan appears to have some advantages over the other alkylating agents in that there is relatively little effect on platelets; also leukocyte recovery is more rapid after cessation of the drug.⁵

Pre-Operative Irradiation

Pre-operative irradiation has been recommended¹⁵ for locally advanced disease fixed to pelvic organs or bony pelvis.^{13, 14} Irradiation causes masses to become smaller and more mobile, facilitates the dissection, and reduces the risk of iatrogenic dissemination. Kottmeier¹³ reported on 104 patients with partial excision of fixed masses: All were dead within 21 months despite post-operative irradiation, and most within six months. In contrast, 20 of 116 with *pre-operative* pelvic irradiation (3-4000 rads in 4 to 7 weeks) and subsequent excisional surgery survived more than three years. A small series of advanced inoperable cases²² treated with abdominopelvic irradiation (3000 rads in 6 to 8 weeks) pre-operatively plus Thiotepa® indicated that gross total removal became possible at "second look" surgery in 9 out of 17 cases.

Radical surgery for locally advanced carcinoma including resection of involved viscera has also been successfully performed¹⁵ after pre-operative irradiation of 4000 rads in 6 to 8 weeks, with 8 of 8 survivors over 5 years.

Value of Post-Operative Irradiation

No controlled randomized studies of treatment of ovarian cancer are available. Ideally, results should be compared for specific tumor types since survival is a function of the biologic activity of the tumor as well as its treatment. However, few such studies exist. Evidence is conflicting regarding the value of post-operative irradiation in Stage I cases, especially Ia. Munnell¹⁹ reported much higher 5 year survival rates with surgery alone for Stages Ia and Ib than with post-operative irradiation (78 per cent versus 54). Other studies² show little or no difference in survival with or without irradiation.¹⁶ On the other hand, very high survival rates have been achieved with post-operative radioisotope therapy or megavoltage irradiation. Muller¹⁸ achieved a 90 per cent 5 year survival in Stage Ia with radiogold (Au¹⁹⁸) compared to 60 per cent before radiogold was tried. Keettel¹⁰ reported a 5 year survival rate of 86 per cent with radiogold after removal of all primary tumor, with or without spill, whereas, a similar group has a 53 per cent survival before radiogold.

Moore's findings¹⁷ with radiogold were the same in the "non spill" group—90 per cent; but were slightly less (64 versus 76 per cent) in the "spill" group.

Megavoltage irradiation of Stage I cases resulted in 4 year survival of 74 per cent (81 per cent with serious carcinomata) in one series;⁶ and 82 per cent 5 year survival of Stage Ia

Table 3
Value of Postoperative Radiotherapy of Ovarian Carcinomata

INSTITUTION	GROUP	NO. OF CASES	TREATMENT	RESULTS STAGE-5 YR SURVIVAL
Western Infirmary Glasgow, 1970	All Cases	72	Surg. alone, or + ChemoRx	II-33%; III-9%
		171	Surg. + Irradiation	II-48%; III-17.5%
Columbia Pres. N.Y.—1968	All Cases	100	Surgery alone	II- 0%; III- 1%
		217	Surgery + Irradiation	II-40%; III-12%
Radium Hemmet Stockholm—1971	Serous Ca	302	Incomplete Surgery* + Irrad	II-23%; III- 4%
	Endometrioid or Mesonephroid	149	Incomplete Surgery* + Irrad	II-60%; III-15%
M.D. Anderson Houston—1969	All Cases	30	Surgery + Irradiation	III-IV-25%
		46	Surgery alone	III-IV-10%
		85	Surgery + Chemotherapy	III-IV-11%

*Incomplete surgery: Inoperable cases or those with incomplete removal of ca, or metastases

cases without microinvasion of the capsule, in another.⁸ There is impressive evidence of the value of post-operative irradiation in Stage II and III carcinomata. Large series from Glasgow² and the Columbia-Presbyterian Hospital in New York¹⁹ reveal distinct superiority in 5 year survival for cases treated with surgery and irradiation versus those with surgery alone or with subsequent chemotherapy. Similar findings were reported in Stages III and IV cases from the Anderson Hospital in Houston.³

At the Radium Hemmet, a large group of advanced carcinomata were treated essentially with primary radiation therapy.¹³ All these patients had metastases and/or incompletely removed or inoperable cancer—see Table 3. Impressive 5 year survival rates resulted in those with pelvic spread (Stage IIB); 60 per cent for the endometrioid and mesonephroid tumors, and 23 per cent for the serous carcinomata. A small ratio of cases with extra-pelvic spread (Stage III) were alive as well. The improved survival with the endometrioid and mesonephroid types indicates they are probably more radiosensitive than the serous carcinomata.

Old Short Hills Road

Conclusions

- (1) The major prognostic factors in treatment of ovarian carcinoma are the clinical stage, the histologic type, and the histologic grade.
- (2) Radiation therapy is an important adjunct to surgery for curative and palliative treatment.
- (3) Cure rates may be enhanced in Stage I disease with post-operative radioisotope therapy or megavoltage irradiation.
- (4) Survival rates of Stages II and III carcinomata are significantly improved with post-operative irradiation.
- (5) Adjuvant chemotherapy may potentiate the effects of irradiation resulting in prolonged survival and improved palliation of far advanced disease.
- (6) Pre-operative irradiation of advanced carcinoma with fixed masses may increase resectability and prolong survival.

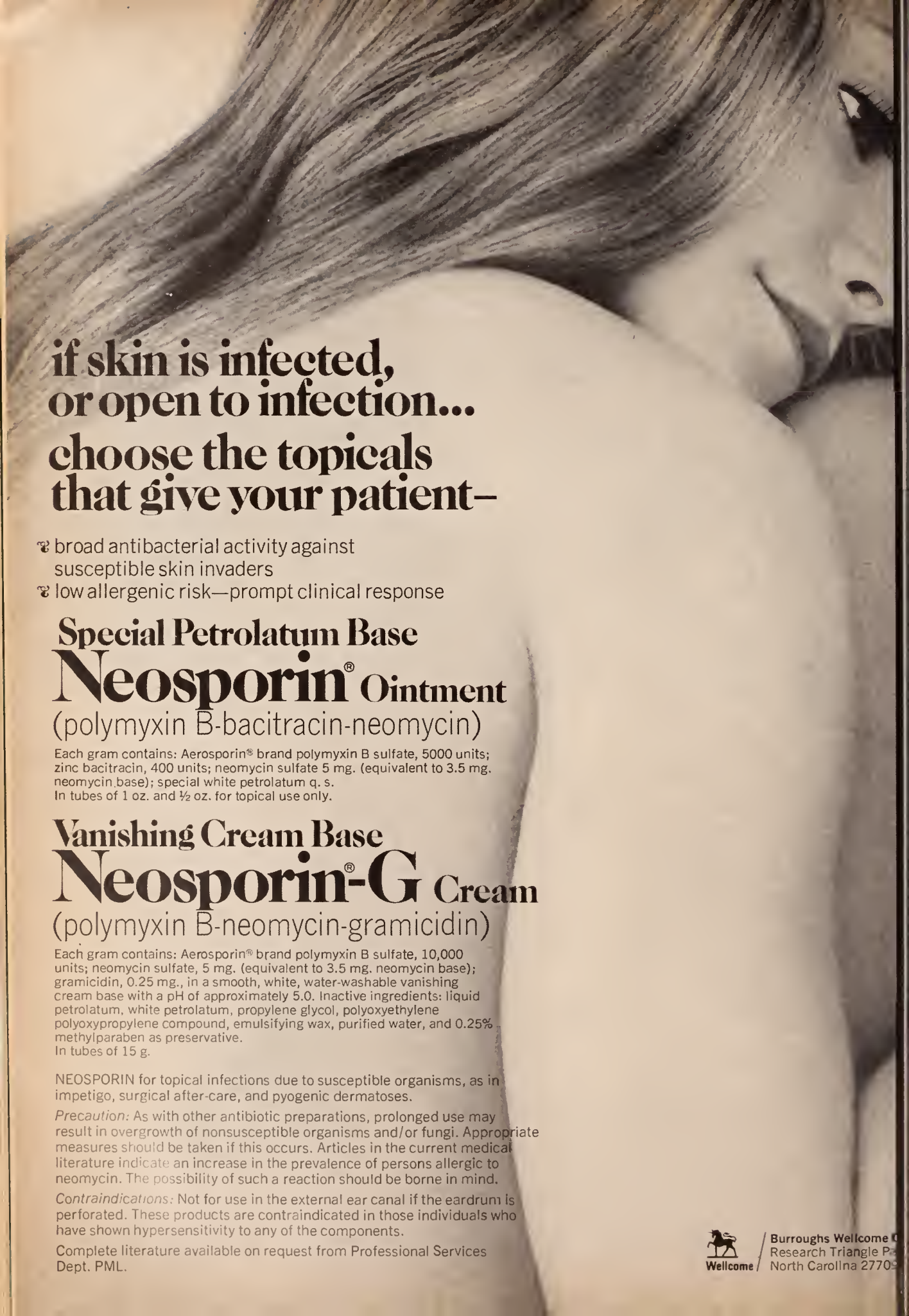
A bibliographic listing of 24 citations will appear in the author's reprints.

New Medication for Alcoholics

A new tranquilizer for the treatment of alcohol dependence, Serenitil® (mesoridazine), has been developed and made available by Sandoz Pharmaceuticals (Hanover, New Jersey). The new agent aims at relieving anxiety, tension, and depression. It has antiemetic properties, an apparent lack of habituating characteristics or hepatic toxicity, and is available in both oral and parenteral forms. In preparation for release of Serenitil®, Sandoz has supported the Center of Alcohol Studies at Rutgers University in a massive statistical survey of alcohol dependence and physicians' attitudes toward the problem, in-

cluding a state-by-state analysis. The survey showed that while New Jersey ranks 7th in the total number of alcoholics, it ranks 10th in per capita number. It was also noted that more New Jersey physicians (compared with the national average) report that at least half their problem drinkers are women.

Sandoz is offering interested physicians a series of recorded panel discussions with leading authorities on alcohol dependence and its treatment. Also in preparation by Sandoz is a directory, a state-by-state reference of treatment facilities and other pertinent data.



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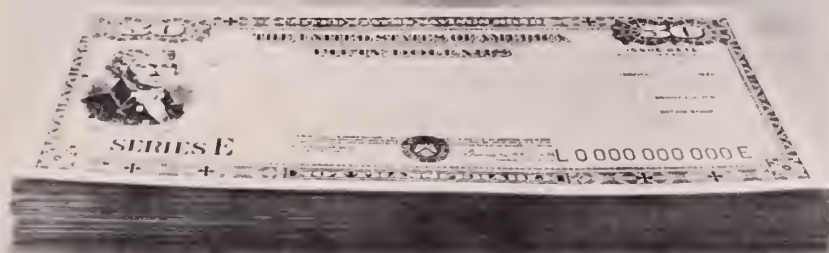
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Facts about activity

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Beta-hemolytic and other streptococci (many strains of

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Staphylococci, both coagulase-positive and coagulase-negative (some strains of staphylococci are resistant to cephaloridine)

Pneumococci

Gonococci

Hemophilus influenzae

Escherichia coli and other coliform bacteria

Klebsiella

Proteus mirabilis

Loridine also has demonstrated activity against *Treponema pallidum* in experimental syphilis studies in animals.

All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine. However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *H. influenzae*, *Pr. mirabilis*, *Esch. coli*, and *Klebsiella* are also susceptible in vitro.

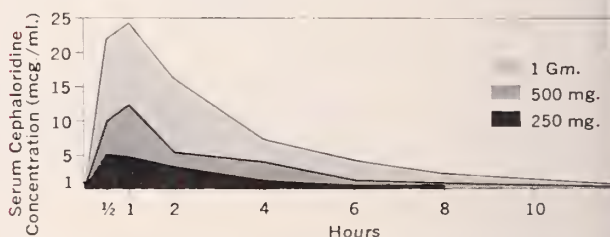
Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Loridine is indicated in the treatment of gonorrhea when penicillin is not considered the drug of choice.



Facts about dosage

In adults, most infections of moderate severity caused by susceptible organisms respond to Loridine in dosages ranging from 500 mg. to 1 Gm. every eight hours (1.5 to 3 Gm. daily). This use of lower dosages helps prevent drug accumulation. The more susceptible infections have been treated with 250 to 500 mg. every eight hours.



Mean Serum Cephaloridine Concentrations after I.M. Administration of Single Doses (250 mg. to 1 Gm.) to Normal Human Volunteers (Six to Eighteen Subjects per Group). (Modified from Currie, J. P.: Cephaloridine: Pharmacology and Toxicology, Postgrad. M. J., 43 [Supplement 22, 1967].)

Peak serum levels have been noted with Loridine within one-half to one hour following I.M. injection. The mean peak serum levels obtained in normal subjects one hour after a 500-mg. I.M. dose ranged from 12 to 22 mcg. per ml. in separate studies. Administration every six to eight hours permits adequate concentrations to be maintained. In order to avoid excessive serum levels (which could possibly result in damage to the kidney tubules), recommended dosages should not be exceeded. In adult patients without azotemia who have mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the maximum recommended dosage is 1 Gm. every twelve hours during the period of reduced function.

acts about administration

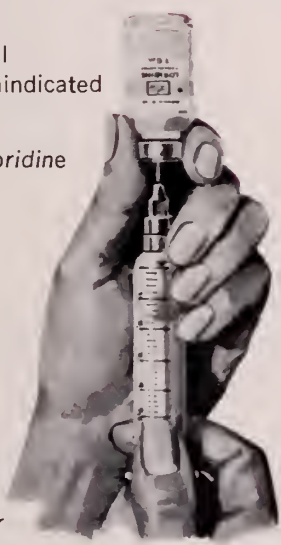
the following guidelines for therapy with Loridine are recommended.

Before Administration of Loridine

- Establish susceptibility of the pathogen.
- Determine patient's renal status; Loridine is contraindicated in azotemia.

During Administration of Loridine

- Maintain proper hydration.
- Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
- Use cautiously with other potentially nephrotoxic drugs.
- Because nephrotoxicity has been reported, limit dosage to 4 Gm. daily for adults (100 mg. per Kg. for children—not to exceed adult dosage).
- Usual adult dosage range: 1 to 3 Gm. daily.



- 5. In patients with impaired renal function before treatment, reduce daily dosage and keep them under close observation for changes in function. In nonazotemic patients with mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage (adults) is 1 Gm. every twelve hours during the period of reduced function.
- 6. In patients who develop impaired renal function or whose preexisting impairment becomes worse *during* treatment, discontinue therapy.

Since Loridine is relatively painless on I.M. injection, it is well accepted by patients.

There is clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins; therefore, Loridine should be used with great caution in patients with known penicillin allergy. Instances of patients who have had severe reactions to both drugs, including death from anaphylaxis, have been reported.

Loridine[®] I.M.
cephaloridine



101553

(Please turn page for prescribing information.)

Loridine® I. M.

cephaloridine

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinistest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred

in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Phlebitis in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important: Before administering Loridine, see page insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 mg. to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when dosages larger than 4 Gm. daily are considered for life-threatening situations. If more than 4 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

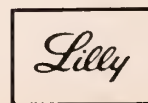
In children, a daily total of .30 to .5 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 10 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

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Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 46201

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Addressed to a State College Institute, Dr. Mettler here offers a point of view on consumer protection in medical care. These, of course, are the views of the author, not of the State College or of The Medical Society of New Jersey.

Is There an Equivalent in the House?*

Fred A. Mettler, M.D./Blairstown

No education is required to be a "practitioner" of medicine.¹ The term may be properly applied to anyone even *attempting* to treat diseases. In Communist China an ancient system of therapy (based upon counterirritation, using moxa and acupuncture) still flourishes alongside scientific medicine and is interwoven with it. In areas where ideology takes precedence over science, scientific medicine is suppressed since it is not possible for reasonable physicians to admit that cure is dependent upon membership in a political party. In any system of medicine, the word *practitioner* may be used for one who is unqualified as well as for one who is qualified and he may be engaged in legal or illegal practice. In most countries if a practitioner is to be considered qualified² he needs a certain amount of training which is the second requirement in safeguarding the public, the first requirement being freedom from political domination.

In the principal powers of the current world, the theoretical education of the individual up to the age of 18 is essentially similar. If the individual completes an additional approved course of theoretical training in medicine he may become a *graduate in medicine* (Doctor of Medicine in the USA and USSR, Bachelor of Medicine and Surgery in the United Kingdom). Such an additional course of training requires from 5 (UK) to 8 years (6 USSR and from 6 to 8 in USA). If the United Kingdom bachelor completes an additional internship year and submits a thesis, he also may

become an M.D. All such persons are then Doctors of Medicine, or more simply "doctors." Of course not all "doctors" are doctors of medicine. The word simply means "learned" and may be applied to musicians or theologians as well as doctors of medicine. In our country a D.O. degree (Doctor of Osteopathy) may be alternatively obtained in a comparable manner. In Great Britain and certain other countries, including the USA, and the State of New Jersey, persons may be admitted to the legal practice of medicine who have *not* been graduated from any recognized medical school. Such persons are properly called licentiates, physicians, or practitioners although individuals of these classes will occasionally be encountered using the designation Doctor of Medicine and signing the letters M.D. after their name. Such usage is justified by the argument that a license to practice medicine is the "equivalent" of the degree of Doctor of Medicine. Boards of Medical Examiners, in some states, may print the designation M.D. on licenses of individuals who have never received such a degree. In New Jersey it is proposed to make it illegal for a practitioner to employ anything but what the Board of Medical Examiners prints on his license. This would mean that a practitioner might be required to designate himself as M.D. even if he were not and had no intention of making any such claim. Such claims are regarded as "regrettable" by the AMA, and foreign accrediting agencies have characterized USA usage in

*Presented at the Consumer Health Institute, State College, Trenton, New Jersey, June 7, 1971.

this respect as "blundering." Official US organizations of physicians, such as the state medical societies, the AMA, and the boards of certified specialists, may be required by law (as in *Pinsker vs. Pacific Coast Society*, California Supreme Court, 1969) to admit such arbitrarily designated persons to membership whether they approve of them or not. Some of our European colleagues call derisively such compulsion *fare ingoiare un rospo*. It should also be clearly understood that the professional organizations in this country cannot get rid of embarrassing presences (*Parsons College Case*, U.S. District Court of Illinois, 1967) once they have been forced upon them (Cardozo, 1970). There is no direct, immediate mechanism available to physicians (or organizations of physicians) to revoke a license once it has been granted by the state. In general, only an actual conviction for a felony may possibly result in the revocation of such a license. Such action cannot be taken by the physicians' organizations themselves. From these considerations it should be clear to the consumer that the profession itself cannot be justifiably criticized if the practitioners in a community are incompetent or if there are undesirables in the professional societies since the profession itself has no effective means of preventing the admission to practice of persons the profession does not regard as adequately qualified and no practical way of getting rid of persons from whom it would like to dissociate itself.

In the USSR, Vietnam, and several other areas, the hierarchy of practitioners includes a special group called *feldshers*. Nurses are also considered practitioners of medicine there. In the USSR and some parts of the USA (including New Jersey) midwives occupy a position in the hierarchy of medical practitioners. The word *physician* is commonly used for practically any of the above groups, except midwives and nurses. The phrase "family physician" is usually employed to mean a doctor of medicine engaged in general practice. Legislation now before the New York Senate would limit this designation to a new, special group of medical attendants equivalent to the Soviet *feldsher*. The *feldsher*

is the professional descendant of the medieval barber-surgeon who became the military surgeon of the 17th century (from the German *Feldscherer*). Because of a shortage of first class doctors in Czarist Russia the *feldscherer* persisted as a kind of second-rate physician. Today the 400,000 *feldshers* currently in the USSR (many are women) constitute a category of specially trained multi-purpose, middle-grade medical workers, not inferior quality physicians. The proposed legislation for the creation of the class of *feldsher* in the USA would restrict the designation *family physician* to a class, the exact training requirements of which are still indeterminate. These people who would, however, hold a Bachelor of Medicine degree would be engaged in "performing presumptive or symptomatic diagnoses and treating or prescribing for any human disease, pain, injury, deformity or physical condition." ("Laverne Bill," proposed article 162, to be added to the New York Education Law) Such legislation in its present form is opposed by organized medicine as exposing the public to unqualified attendants.

A *certified specialist* may be a person who has undergone recognized postgraduate training and passed special certifying examinations offered by professional boards. Certified specialists have no distinctive legal status, since the certifying boards are not government agencies. Certified specialists are expected to restrict their practice to the area of their specialty but do not always do so. Some use the curious word *specialoid* for a physician who has developed a restricted type of practice without having followed the training course prescribed for the certified specialist. It is almost impossible, even for professionals, to determine from the labels just exactly what the training, qualifications, or current activities of such persons might be. The trend is toward less rather than greater clarity. Practitioners of medicine in the USA are required to display their Doctorate of Medicine Diploma, State Board of Medical Examiner's License, and Tax Stamp for narcotic and other dangerous drugs. If these are *not* displayed, it may be assumed they do not exist. Certificates from specialty boards are usually

displayed if the physician is a certified specialist but, some so-called "specialty" boards do not enjoy any high order of respect.

In the USA the patient is unrestricted in his selection of a physician on the basis of a direct patient-physician relationship and without third party interference. In such a system the most important safeguard of the consumer is his own critical judgment. Consumer protection in such a system means something very different than would be meant in the USSR where the patient is required to go to the particular "doctor-of-first contact" assigned to the district (*uchastok*) in which the patient is residing, or to the district clinic if there is one. The Soviet patient has no more choice about his medical attendant than the United States patron of a post office has about the clerk who will serve him. There is no patient-physician relationship in our sense of the term, since the Soviet physician is an agent of the state. It is assumed, in totalitarian systems, that there is no need for the consumer to exercise choice because he is protected, the state being both a designer and deliverer of the system of medical care. Logically, in such a system, one cannot have any complaints since the system is designed to meet all the needs of whatever situation may conceivably arise. According to this line of reasoning the responsibility of the state is total. If results turn out to be less satisfactory than the patient or his relatives anticipated, the state will take care of the unfortunate consequences through a system of closely interlocking agencies. If medical service is not delivered as planned, there are channels through which complaints can be filed. The logic of this system is forceful and the figures available to back up the logic are impressive but the American public is less favorably disposed to the imposition of such a degree of regimentation than is its Soviet counterpart.

However, it must be pointed out that there is also room for some skepticism about the degree of free-choice which the citizen of the USA can exercise in matters of medical care. A system of free choice of one's medical attendants is not very meaningful if no desirable

attendant can be found. Furthermore, the knowledgeable resident of New Jersey who is familiar with reports such as that of the Survey Board of the American Psychiatric Association† will note that the program recommended by the survey board is dependent upon the *uchastok* principle of sectionalization. This essentially deprives the patient of any practical degree of choice. It is true that the APA envisions the possibility of free choice of physicians in state hospitals, but from a practical point of view the state psychiatric hospital programs of nearly all jurisdictions are run on the *uchastok* plan. Patients in state hospitals have the legal right to appeal to the state with regard to the quality of medical care they get but this is a corrective not preventive mechanism. From the consumer's point of view, the *uchastok* system, whether run by a democracy or totalitarian power, affords the consumer only such protection as may be built into the system. In the totalitarian system the state not only accepts total responsibility, at least in theory, for failures but also has an integrated system to take care of unfortunate consequences. The democratic society which employs the *uchastok* system generally does not accept any responsibility for failures but only (and again in theory) for negligence. In cases of professional error it may not admit liability unless it can be forced to accept legal suit and can subsequently be proved to have been negligent. Even then, if one is successful in what for most people would obviously be a prohibitively expensive legal battle, there is still relatively little opportunity for the recovery of any substantial amount for damages.

Consumer Protection in the Free-Choice System—In the patient-physician relationship, under which a significant part of medical care is still conducted in the United States, it is assumed that the patient knows what he wants by way of medical care and how to go about getting it, or at least is not deliberately intent upon deceiving himself. Are these assumptions justified? The USSR bureaucrat

† *Mental Health Needs of New Jersey*, American Psychiatric Association, Washington, D. C., February 1971.

would say it is not. Hippocrates pointed out in his first aphorism, that it is not enough to prescribe for a patient—one must be able to *manage* matters on a more comprehensive scale. "The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and the externals cooperate." It has been asserted by many observers (Flexner (1910) among them) that there are some persons who contribute to their own confusion and deception because they cannot think clearly or have personality problems. It is very difficult to protect such consumers. Our state's Professional and Occupational Licensing Study Commission (Report of January 7, 1971) threw up its hands when confronted with the specter of full paternalism advocated in totalitarian governments and decided that the state could not be expected to regulate everything. It recommended that state licensure³ should be restricted to the coverage of those personnel services which require qualifications of such a specialized or complex type that the ordinary person cannot be expected to come to an unaided opinion as to their adequacy. The practice of medicine and surgery was one such area in which state licensure was considered to provide definite consumer protection. This Commission did not explore the opportunities available through the British system of registrable qualifications in the case of medicine, as opposed to the procrustean gymnastics required by licensure under the State Boards' System. The fact is that while there is relatively little chance of deceiving any but the most gullible persons by the frauds⁴ which Morris Fishbein (1925) called the "medical follies" even very sophisticated legislators easily become hopelessly confused by superficial appearance in the labyrinth of licensure. The commission made an illuminating plea for licensing agencies to provide the public with information "written clearly, about how to enter a profession or occupation. It wants to know what to do with complaints. It wants to know what standards practitioners are expected to follow, if any. It wants help from agencies that were established to serve the public." The arresting aspect of this statement is that it demonstrates that a dedicated group can

itself present the public with ambiguous data, even though it knows that what the public needs and wants is clear factual information. For example, when one examines the educational entry requirement supplied by the Commission for the profession of "physicians and surgeons" (graduation from medical school or college) one is forced to admit that this unqualified statement is not in full agreement with the law in operation at the time of the report (NJRS 45:9-8) which is explicit in allowing for equivalent exceptions to the requirement of "graduation from medical school or college."

Consumer Protection at the Level of the Medical Colleges—Up until 1910, medical education in the USA was a jerry-built complex with some fine establishments interspersed among many shabby, run-down, but still respectable organizations, and a distressingly large number of outright fraudulent ones, the diploma mills. "There is," Flexner wrote in 1910 "no protection against fraud or forgery" and again "the state board is legally powerless." A similar situation existed abroad. The scandalous "extramural schools" in Scotland and the venial *Zengnis* (certification) vendors of Austria, especially, come to mind. The Carnegie study of 1910 exposed the extent of patient exploitation in the USA. This helped bring about the closure of the worst institutions here and the consolidation of many others during the social changes attendant upon World War I. The Austrian establishments went down the drain due to the collapse of the country. Some of the "extramural" schools in Scotland staggered along on oatmeal rations for a while and the remainder finally "slippit awa like a knotless thread" in the fifties. In the USA, a generally satisfactory system of regular inspection and accreditation has been carried on in recent years by the American Medical Association and the Association of American Medical Colleges. Individual schools (such as those in our state) have had periods of considerable difficulty but the general level of education has been satisfactory. More recently, with an increased demand for medical manpower and a shortage of teachers, the situation has once again

become strained. At present, with deficits requiring cut-backs, in the face of an increased demand for any kind of medical attendant that can be dredged up from the bottom of the manpower barrel, most schools are having difficulty in keeping up the standards they feel should be maintained. We are obviously on the verge of a return to the psychology of the diploma mill era rather than engaged in intelligent planning to make efficient use of what we have.

Foreign-trained physicians have been drawn from areas which are widely divergent in respect to standards and subjects studied. There are schools of outstanding merit in many foreign countries. However, the student who graduates from a superior foreign school is less likely to be interested in emigrating to the USA than is his less talented and less fortunate compatriot. The situation of the American-born, foreign-trained medical student is no more satisfactory than that of the foreign-born immigrant who had the advantage of being familiar with the milieu in which he studied. "Foreign medical graduates who are US citizens fail the ECFMG and the licensure examinations in the same proportion as all foreign medical graduates" (Millis, 1971). The supplementation of medical physician manpower with foreign graduates is a selective process which operates in favor of the selection of less successful individuals regardless of their national origin. There is a marked difference between the attitudes of the governments of the United Kingdom and the USA with regard to foreign students. Sixteen pages of a recent Royal Commission report (1968) are taken up with the responsibilities of the UK in helping to train medical personnel for less privileged areas. In the USA this responsibility has been recognized by the establishment of a foreign medical graduate program which Millis (*op cit.*) has characterized as "a can of worms" because among other things "it has become, to a large degree, a mechanism for the entry into medical practice in the US." That it and the brain-drain imposed upon foreign medical schools have become such problems is due in no small part to the active encouragement by

those legislatures in the USA which have taken a position which is the reverse of the UK in exploiting under-privileged countries as a source of medical manpower and as locations in which to train US citizens who have been unable to gain entrance in our own medical schools. The unabashed expression of such selfish sentiments has not enhanced the US image abroad and schemes for retaliative action are under consideration by the undeveloped countries that are in much greater legitimate need of medical manpower than we are, and whose citizens are being taxed to educate people who are then drained off by us.

Although many foreign schools are well-known to educators in this country, it is impossible to keep track of the more than 776 such schools which were said to be in existence in 1969, not counting those in China, East Germany, the European part of the USSR and certain other areas. The situation of most of these establishments changes constantly in response to the rapidly fluctuating political and economic conditions in which they are located. The medical curriculum in such schools varies from 4 years (in the Canadian schools, which are comparable to those in the US) to 7, in places like Belgium, Surinam, Indonesia, and South America (where what is considered pre-medical training in the USA is included in the medical curriculum). About half the foreign schools require the completion of at least one additional year to be spent in an internship before the instructional program is actually complete, because the first part of the medical curriculum in such countries corresponds to what is called "premedical" here. Thus a seven-year foreign curriculum may require one more year to bring it up to the combined eight years of the USA schedule of 4 years of pre-medical and 4 years of medical training. A person completing three years of medical training in Belgium is not intended to be compared with one completing three years in Canada, since the Belgian degree of *Cand. en Sc. nat. médicales* is, in fact, only the pre-medical part of a full seven year course. The internal controls which have been operative

in the USA in recent years have produced a reasonably uniform domestic product, which has afforded the public with a practical degree of protection. This is now threatened because medical schools are currently under great stress, subject to considerable erosion and in serious danger of deterioration. Further it is practically impossible, except in certain fortunate cases, for the State Board of Medical Examiner system satisfactorily to evaluate the qualifications of a not inconsiderable number of foreign-trained medical graduates.

Protection of the Consumer at the Level of Postgraduate Education—Once the physician has graduated from medical school, two paths lie before him. Either he is to proceed as quickly as possible into practice or he may elect to continue his post-graduate education for a period of 3 to 5 years with a view to becoming a certified specialist. If he decides to go into practice as soon as possible, he will be required to serve a clinical apprenticeship in a hospital, the internship. This is a critical period for him and perhaps even more so for the patients with whom he comes in contact. The situation of both will be greatly improved, if he works under the direction of a talented informed senior staff. Unless an internship is "approved" the young physician can expect no training credit for it though he may be very well paid, in which case he is likely to be treated by the hospital administration more as "hired help" than as a professional person. Young physicians "seek . . . internships and residencies almost exclusively in hospitals and medical centers identified and affiliated with medical schools." (Satulsky, E., as President of The Medical Society of New Jersey, in a letter addressed to the Trustees of CMDNJ, February 8, 1971) Less desirable students often find themselves forced to mark time in unwanted approved or even unapproved internships, and patients who come under their care may be exposed to serious hazards. Many patients who enter unaffiliated hospitals did not expect to be placed in the hands of interns since they engaged their own family physicians who then arranged for their admission to the hospital.

Once in the hospital, however, they may discover that their medical care falls essentially into the hands of inexperienced and relatively unsupervised young doctors who are often disgruntled by their situation and cynical about their professional superiors.

The situation of the patient in the well-supervised, approved internship hospital is likely to be more fortunate. Even though he may be unable to pay for a private physician he is still usually assured of the same quality of medical care as an affluent patient in the private pavilions of the same hospital. Indeed, he may be much better off, from a medical point of view. Here is a situation in which a lack of choice of one's physician can be preferable to the choice of a physician who is blocked from taking care of his patient once the latter is in a hospital, or who just shirks his responsibility.

For a hospital's internship program to be accredited, the interns are expected to meet minimal standards which, for foreign graduates, include a special examination developed by the Educational Council for Foreign Medical School Graduates (ECFMG).

Speaking as a Britisher, John Fry (1970) has commented, "There is no simple recognizable pattern of American hospitals. They cannot be graded readily according to population served or size of roles because there is so much overlap." It is probable that protection of patients confined to institutional bed-care reaches its lowest level in unaffiliated hospitals. Since 55 per cent of the total number of hospital beds are under state or municipal control this is a problem of considerable political importance. In New Jersey, relatively few hospitals have approved internship programs and only a handful of them are affiliated. The performance of even this small group is further threatened by the recent passage of Assembly Bill 2131 which blocks hospitals from the use of ECFMG examination in the following manner:

"No hospital licensed by this State or operated by the State, a county, or a municipality and which receives funds pursuant to the 'New Jersey Medical Assistance

and Health Services Act,' P. L. 1968, c. 413 shall require an individual as a condition to serving an internship in such hospital to take an examination other than an examination which may be required by rules and regulations of the State Board of Medical Examiners."

In a long statement justifying this legislation, the sponsors argued that "many hundreds of qualified New Jersey medical students—are compelled to attend foreign medical schools." "The University of Bologna in Italy and University of Guadalajara in Mexico" are specifically stated to be the locations at which many such students are to be found. It is stated that the requirements of these foreign schools discriminate against New Jersey citizens because New Jersey residents do not need all that Italy and Mexico require of their own citizens. What is the meaning of the word "compelled?" Does our State really require "hundreds" of new doctors every year in addition to those currently studying in its two medical schools, and cannot those who are additionally needed be obtained from other schools in the USA? Further, if Italy and Mexico believe their graduates need certain requirements why should New Jersey require less? If these things are true what is wrong with the State of New Jersey that it is so unattractive to superior medical talent and why should New Jersey seek dispensations for its residents from countries that do not exempt their own citizens from such requirements to enter into practice? Of 508 internships offered within the state only 62 per cent were filled and 87 per cent of those were filled by graduates of foreign medical schools. This can only mean one thing: that the internships in New Jersey hospitals are not considered worth having by most of the graduates of our own schools. This, not merely a lack of physicians, is the primary problem. The bill's sponsors predicted that it (A-2131) will improve the quality of medical care. Ordinarily one does not expect legislators to undertake the role of prophets about subjects concerning which they have no special knowledge and The Medical Society of New Jersey had a different opinion about the consequences of this bill (*The Journal*, MSNJ, 68:435) and disapproved it "because enactment of this legislation would ultimately result in the withdrawal of approv-

al of internships and residencies in hospitals that act in accordance with its provisions." This applies to our really superior hospitals and those that are doing their best to protect the public. But there are other and even greater dangers in this law. For example, on February 8, 1971, Emanuel Satulsky, M.D., then President of The Medical Society of New Jersey, presented the Trustees of the College of Medicine and Dentistry with a statement from the Trustees of the MSNJ in which it was pointed out that the state was not fulfilling its obligation to the people of New Jersey by way of training of physicians and that educational doors in other states were being closed to New Jersey residents. The Trustees of the Society did not envision the importation of foreign-trained physicians as the solution to the medical manpower problems of our state. If we allow ourselves to rely upon foreign training for the supply of physicians there may be less incentive to support and improve the training being provided in our own medical schools which offer the best hope for solving the medical care problems of our inner cities. New Jersey blacks cannot afford to go to Italy or Guadalajara and the students of schools in those locations have expressed no urge to engage in inner city practice in Newark, Camden, or New Brunswick. Ultimately, reliance upon foreign training will hamstringing our own medical training programs with closure of the only channels of personal development easily accessible to our inner city populations.

After the passage of Assembly 2131, the State Department of Law and Public Safety apparently felt some prophylactic action was required and published amended sections of an "Emergency Rule Pertaining to Graduates of Foreign Medical Schools or Colleges" (NJLJ 1971, index page 390). Included is the following, "Before a foreign medical school graduate may intern in a New Jersey hospital, he shall successfully demonstrate his didactic and clinical experience by passing the ECFMG examination or an examination prescribed by the State Board of Medical Examiners adequate to judge his knowledge of the science of medicine and the healing arts

and the extent of his clinical competence."

From this it would seem that the ECFMG is to be mollified by having a state administrative department require the examinations which hospitals were prohibited from giving in the first place. On the other hand foreign students whose gains might be nullified by this rule could be rescued by an opportunity to take a different examination given by the State Board of Medical Examiners. We again encounter here the introduction of the critical concept of "substitutive equivalency" which Abraham Flexner identified as the hallmark of survival of what he called his third class of medical schools in the 1910 Carnegie report.

Protection of the Public at the Level of Admission to Practice—Once the physician has completed his academic medical training and obtained a minimum of clinical training he may apply for a license to practice medicine. While there is much that is disorderly, confused, and dangerous from the consumer's point of view in the internship year, probably nothing so enrages the public as the granting of licenses to unqualified persons, as is further noticed below in connection with a quotation from D. B. Dove. Under the circumstances it is not surprising to find that the agencies which grant licensure for the states (State Boards of Medical Licensure) are decidedly cryptic in their statements and actions. While they are under constant pressure from many opposing interests, they are ultimately forced to follow the dictates of legislatures about which nothing is predictable except unpredictable change. The statutes of medical licensure of the various states are a museum of strange and often superficially incomprehensible law. It should be understood that licensure by the Boards of Medical Examiners of the various states does not signify excellence in medicine but merely compliance with legal requirements. Our State's Professional and Occupational Licensing Study Commission apparently believed that it was necessary (at the time of submitting its report) for a candidate for licensure to have graduated from a medical school but we have

noted that this is not necessarily the case. For example, NJRS 45:9-8 at that time read, in part, as follows "Every applicant—shall—prove—that he has received (a) a diploma from some legally incorporated professional school—or (b)—a diploma or license conferring full right to practice all of the branches of medicine and surgery in a foreign country." The act goes on to state that even if the applicant cannot meet the requirements of the right to practice, he may still be admitted to examination for licensure if he has put in three years of internship, or other hospital training, and could prove that he had studied for four years in a recognized professional school. Since we have already learned that there is no such thing as a license to practice medicine in Britain, one would suppose that if a student in Britain had been unable to obtain a diploma he would be ineligible for licensure in New Jersey, but the license has evidently been granted under such circumstances. The reasoning would appear to be that registrable qualifications are the equivalent of a license. Registrable qualification can be obtained in Britain by persons who have never been graduated from any professional school. The regulations of the "Scottish Triples" are explicit on this point. Under the provision of this act (and by the use of discretionary powers and utilizing the employment of the concept of equivalency) it is not necessary to have graduated from any professional school. It is not specified in what manner a candidate is required to prove to the Board of Medical Examiners the issue of attendance at a recognized school. Could he be said to have attended a school to which he was never admitted, for example? Neither are we informed whether the Board is under obligation to determine whether appropriate records exist *in the educational institution* in question or whether there is any discrepancy between the candidates alleged proof and such records as may exist. There is some reason to question whether the records of the State Board of Medical Examiners always agree with the records of the institutions from which a person is said to have graduated. The candidate seems not to be specifically required to present *official* documents from

the school *itself* demonstrating that he had been registered as a properly admitted and matriculated student in that particular institution, or that he was admitted to the final examinations for a recognized professional degree *granted by it*, or that he had passed the examination required *by the particular institution in question for the particular degree specified*.

One of the strangest pieces of legislation in this field is NJSR 45:9-8.1 which evidently provides for the admission to examination for licensure of a person who may have attended lectures (the law does not require that the work done in the course attended shall have been satisfactorily passed) in a medical school. (It is not said that the candidate must have graduated from the school.) He must have completed an internship of 18 months and spent 15 years as a resident member of the staff of an approved hospital.⁵

Then we had Senate Bill 2083 which reduced from three years to one year the length of internship for students trained in foreign medical schools, but unauthorized to practice in the country where the school is located. This bill has to be viewed in association with the emergency regulations published in the N. J. Law Journal (index page 389) which define a foreign medical school as one included in the WHO list of foreign medical schools. The current edition of the WHO's World Directory of Medical Schools was published in 1963 and it is served by a supplement dated 1967. The third edition states, "The listing of a school in the directory is *not* meant to be a recognition of the value or level of teaching but merely a fact of its existence and functioning." It is further necessary to qualify even this restrictive statement by observing that no information is given in connection with many of the medical schools which are listed in the supplement as to the nature of their functioning. For example, four medical schools in Peru are listed without faculty or students. How does such an institution without faculty or students function? Further, the nature of the type of functioning of the schools listed as having

faculties frequently cannot be evaluated from the information which is provided. For example, Estudos Gerais, Universitarios de Angola, Luanda, Angola, is said to consist of a faculty of fifteen part-time people for 163 students. We are not told how active these part-time people are, what their qualifications may be, or what functions they perform.

The combined effects of Senate Bill 2083 and the subsequent emergency regulations would thus appear to be to force the Board of Medical Examiners to evaluate students from schools which schools cannot themselves be evaluated. Senate Bill 2083 was formally opposed by The Medical Society of New Jersey. For anyone who labors under the delusion that physicians exercise powerful political influence, the votes on these two bills are instructive. The passing vote for Senate Bill 2083 was 33-0 in the Senate and 55-0 in the Assembly. Assembly Bill 2131 passed in the Assembly 67-0 and in the Senate 30-0. From these figures it would appear to be permissible to conclude that a trend might, with the exertion of some effort, possibly be discerned. All this suggests that the current organization of the State Boards of Medical Examiners is of such a nature that it places these Boards under immediate legislative direction and that, in instances where legislative directive is in conflict with the formal position taken by the profession, the State Boards are forced to follow political directive instead of accepted medical opinion. The State Boards may be presented with directives which it is difficult to see how they could possibly carry out. Different directives may be given to different boards by different legislatures. The prospect of the gross waste of time and effort in attempting to discharge impossible tasks staggers comprehension. Unless the professional members of the State Boards agree with the thrust of political directives their considered professional opinion may be ignored and, ultimately, they could be replaced by more acquiescent professionals drawn from the political services. Among the actions which may legally be forced upon the State Boards by legislative process is evidently the admission to practice of persons who never actually

graduated from a professional school and of persons who, the medical profession may believe, are not ready to be admitted to practice. The Boards are also forced into conflict with national agencies of accreditation.

It is difficult to see how this can be reconciled with the prospect of a nationalized system of health insurance. If anything like uniformity is to exist in the practice of medicine in the USA, a uniform set of qualifications will obviously have to be developed for the country as a whole. We should review the egregious practice of substituting "equivalents" for the real thing—*ad hoc* examinations as the equivalent of a recognized and standardized examination, certificates for the genuine Doctor of Medicine degree, fraudulent terms such as "family physician" for what would actually be a feldsher, the use of evasive expressions such as "attended four sessions of x weeks in a recognized college" for "graduated," and the practice of allowing persons who merely hold legally acceptable qualifications to identify themselves as Doctor of Medicine.

What is needed in order to achieve adequate consumer protection are:

- (1) A uniform set of standards for qualification for entrance into specific levels and types of medical practice,
- (2) Uniform national examinations, and
- (3) Either a national license to practice medicine which reflects the type of medicine (or surgery) the individual is qualified to practice or, following British custom, the substitution of the concept of registrable qualifications for that of licensure.

The position taken by the Professional and Occupational Licensing Study Commission encourages the growing trend toward the use of national board examinations. Since the Commission approved the principle of endorsement of licensure, it has aligned itself with the concept of national licensure. Certain elements in the legislature are bitterly opposed to such conformation and a long battle will undoubtedly be fought before either of these proposals is actually adopted.

Public Protection at the Level of Postgraduate Training, i.e. Specialty Practice—In the

event that the recent medical school graduate elects to pursue a program of postgraduate training, a number of organized programs are available to him. If he wishes to become a specialist in an administrative field such as public health (rather than in clinical medicine) he returns to the university as a candidate for a Doctorate in Public Health. Other types of specialized training exist. If he intends to be a pharmacologist he may enroll as a candidate for the Doctorate in Philosophy, in pharmacology or biochemistry or physiology. If he wishes to be a pathologist he looks for a hospital residency which has been approved by the Institutional Review Committee of the American Board of Pathology. A candidate for one of the clinical programs ordinarily applies for a residency program which has been approved by representatives of the AMA and the appropriate specialty boards and specialty societies. Many of the recognized specialty programs are actually sub-specialties. Few if any pathologists are accredited as specialists in all branches of pathology. There is an American Board of Psychiatry and Neurology (and many specialists who have been certified by it say just that) but relatively few physicians are certified in both psychiatry and neurology. A certain amount of probing is usually necessary to discover that a specialist's certification is limited to a subspecialty.

How does one find out whether a physician is a certified specialist, what kind of a specialist he is, and what his background may be? There is a *Directory of Medical Specialists* which carries the imprint, "Published for the American Board of Medical Specialties," which states, "The searching investigation and the rigid examination of each diplomate certified by the specialty boards give an authoritative stamp of approval to his status as a qualified specialist" but the American Board of Medical Specialties does not accept responsibility for all that appears in the Directory. The following succinct statement used to be buried in front matter: "The Directory and its publishers are not, therefore, responsible for inaccuracies or omissions." This has now been replaced by reference to

inevitable inaccuracies of computer systems. Actually, while the ABMS accepts responsibility only for the accuracy of the statement that a person was certified by a particular Board, "the biographic data are furnished by the diplomates themselves." Therefore, the only person responsible for most of the material in the *Directory of Medical Specialists* are these same people who are listed in it. The American Boards of Medical Specialties have mechanisms theoretically able to eliminate misleading information, but no systematic evaluation or verification of what is submitted, and there is considerable doubt that the Boards are legally able to sustain the ejection of a diplomate who has not had his state license revoked. Courts often assume this publication is a source of authoritative information. There is no easy way for a patient to be certain what a claim of "certified specialism" may mean. The patient might take the following steps: (1) look at the certificate the specialist should have on display in his office; (2) find out from the board named on the certificate, if the doctor was actually awarded such a certificate; (3) ascertain from the AMA whether the board in question is a recognized one (there are several official-sounding specialty "boards" that enjoy no substantial reputation); (4) check the current performance of the man in question (although he may have been certified by a recognized board at one time, he may since have become a drunkard or senile). All specialty boards do not regularly conduct full, systematic investigations into all the credentials of all diplomates. It is possible for a person who has apparently never graduated from any school of medicine, to obtain certification and turn up in this publication, carrying the label "M.D." Certification guarantees neither the quality of the work a man is currently doing nor its nature. A valid, certified specialist may be doing something for which he is not qualified. One finds men who are certified specialists in one field dabbling in others. While this is ethically *verboten* it is not illegal and thus far, in the USA, where all specialists also hold unrestricted licenses, there has been no effective means of controlling such marginal activity.

In the USSR the situation is very different because the specialist is put in a particular slot in a well organized, total plan, and, theoretically at least, nothing gets to him that he should not be handling. Presumably the same situation will ultimately develop in the USA. In the meanwhile the consumer is confronted by potential confusion.

Consumer Protection at the Level of Established Practice—Once a physician has been admitted to practice protection of patients is limited, from a practical point of view, to what is done in hospitals. In many states, the only grounds for revocation of a license are those of the common law—moral turpitude or insanity. In New Jersey, these principles are rendered explicit and expanded in NJRS 45:9-16, which provides for revocation in cases of insanity, habitual drunkenness, or the personal use of narcotic drugs, moral turpitude (including criminal abortion), fraudulent advertising, or acceptance of employment by one advertising fraudulently, presentation of fraudulent credentials, employment of unlicensed personnel, or gross neglect. Hospitals are more easily accessible to demonstrations of liability than is a private practitioner. Hospital practice is open to peer review. Thus, the conduct of physicians in hospitals can be expected to be of a generally superior quality but among hospitals there still are great differences. Hospitals affiliated with or run by medical schools generally afford the patient the best protection since such institutions cannot afford to allow questionable practitioners to come into contact with students and set them a bad example. Even in the university hospital, however, it is often difficult to get rid of the substandard practitioner or one who has become senile. For this and other reasons hospitals generally extend staff privileges rather warily and only for limited periods of time. Unfortunately such laudable caution has generally been set aside by the courts on the basis that it denies duly licensed practitioners full accessibility to tax-supported institutions. Thus there is a constant tug-of-war going on between good hospitals that are trying to improve the standards of the work being done in them and the

courts that are trying to open their facilities to any practitioner who holds a license. A medical society can censure physicians whose practice involves unethical elements but the societies are ordinarily not permitted to enter into disputes between a patient and physician where the issue is one of malpractice. Such complaints fall under the jurisdiction of the courts and no final conclusions concerning them can legally be reached until all the evidence is before a court. Censure by professional societies has no legal force and is generally shrugged off by marginal practitioners for whom professional ostracism has become a way of life.

Sometimes, a hospital is itself a marginal operation, is unable to obtain sufficient numbers of first-rate physicians, and has to accept whatever personnel it can get that is legally permissible. Under such conditions, the level of practice cannot be expected to be as satisfactory as in institutions that are in a position to pick and choose their staff. Efforts to raise the level of practice in unaffiliated hospitals are often unsuccessful for the reasons that (1) experienced teachers to instruct the staff are difficult to obtain, (2) the staff is often inadequately prepared to profit from instruction, (3) staff members frequently accept such posts only as temporary stopgaps and have no real interest in the work or intention of making a career at such a level of practice, (4) serious language problems⁶ may impair communications, (5) such organized programs of ongoing education which are presented are generally conducted as lectures at which attendance is required rather than desired (for example, it is usual for a monitor to be provided *and* the "students" are required to sign an attendance roster), and which are often considered as merely irrelevant interludes from more boring bureaucratic routines, (6) the measure of accomplishment is usually the writing of a nominal examination which is not corrected by the actual instructors, and (7) the monitors and directors of education are themselves poorly qualified for their task.

One mechanism which has been proposed for

maintaining a satisfactory level of performance in the field of medical care is requalification. Under such a plan the physician would either have to present himself at periodic intervals for renewal of his license or else present evidence that he has completed a certain amount of work designed to keep his education up to date. The President's Commission on Health Manpower has recommended relicensure and the American Board of Family Practice requires its members to present annual evidence of attendance upon a certain number of hours of any of a considerable number of approved courses.

There are grave difficulties with the utilization of these proposals in our system of medical care. The proposal of the American Board of Family Practice can easily degenerate into degraded *pro forma* compliance such as is prevalent in the enforced type of hospital educational program. The proposal of the President's Commission would not work unless the present system of State Boards of Medical Licensure was abolished. Unless the existing mechanism of State Board Licensure were replaced with one for a national license, the relicensure system would result in concentration of the best and worst physicians in absolutely separate areas and the populations of some states and economic groups within states would be forced to accept intolerable levels of care which could be given rubber-stamped approval, as has already occurred in Quebec where dental examinees who failed to pass were accorded provisional licensure anyway. It is easy to see that rather than lose what medical manpower they have, state and municipal services might resort to the power of *fiat* in order to stay in operation.

Effect of Socioeconomic Factors upon the Level of Care Available to the Consumer—Notice the following paragraph in the Report of the N. J. Professional and Occupational Licensing Study Commission:

"The Commission was alarmed to hear of the inadequate or declining number of practitioners in some professions or occupations who locate in low-income areas. Licensing agencies expressed concern about this question, but generally felt helpless to do much about it. The Commission believes that when

a clear need exists, the question of where practitioners practice does involve the public interest and, as such, is a proper concern of licensing agencies. What can be done to encourage the location of practitioners in areas of need is a matter that bears exploration."

Statistics on low income areas are tricky to evaluate because of the fluidity of the underlying population. What does seem to have occurred recently is that many *municipalities* and *states* have decreased the size of facilities for taking care of patients in such areas. Further, one is moved to ask how it is possible to reconcile the position of a state, which has a law like NJSR 45:9-8.1 on the books, and which is moving in the direction of lowering the standards required for proper hospital care (as is proved by the reaction of our State Medical Society to recently proposed and passed legislation) with the suggestion that its physician population should be required to accept compulsory assignment of service. And, *inter alia*, which has elsewhere in its report suggested that the same physician population should submit itself for periodic re-evaluation by the same agency which has licensed persons who have evidently never graduated from any medical school at all. If, however, we assume that by the introduction and liberal application of omnipresent concepts such as discretionary power, equivalency, and the like, such apparent inconsistencies could be reconciled, we still must admit that any workable solution to the problem of maintenance of standards must depend upon how the evolving program of national health service develops. If the maintenance of standards is a concern of the government, the government has to develop within its comprehensive program an appropriate mechanism for dealing with it. Patchwork, *ad hoc* solutions can only compound the existing confusion. The first question is whether even the limited degree of free choice of one's medical attendants which still exists in the USA is to endure. There are a considerable number of dedicated and often very highly trained physicians actively engaged in grappling with the medical problems of the inner city. They are slowly, but surely and successfully, developing, within the inner city population, qualified successors. The mere admission of

inner city people to an opportunity for medical education does not ensure an adequate supply of medical personnel for the inner city since there is no assurance that people born in the inner city are not going to reject its efforts to make claims upon their consideration. The assumption that the admission of substandard outside physicians to the practice of medicine will alleviate the medical personnel problems of the inner city is unfounded because there is abundant historical precedent for the inability of political systems to make medical personnel conform to their wishes. Medical skill is extremely mobile and responds quickly to economic changes and pressures, giving rise to the ancient Assyro-Babylonian maxim that "The kind of medical care a community has is precisely the kind of medical care it deserves." (Mettler, 1947). This is doubly so because it is not merely the behavior of physicians which it is difficult for politicians to control. Legislators also tend to reckon without taking the reaction of patients into consideration. Legislators and philanthropists are frequently puzzled and exasperated by the way in which people in rural areas or the inner city, who have had inadequate medical services, behave when medical personnel is put at their disposal. In such a situation there is an even chance that such personnel may not be utilized, or if it is, may not be accepted as satisfactory. Paramedical personnel is usually indigenous, and professional personnel exogenous. Friction may then arise and circumstances develop which may make it impossible for the professionals to do satisfactory work. Even professionals of like ethnic origins may be nullified. The explanation for such resentment has been verbalized in a statement by Dennis Dove (1970), "But again I would strongly emphasize that blacks and other minority groups are determined to react even more violently if hordes of unqualified individuals of their own kind are unleashed to practice on them." People don't want someone who is just standing around, or worse yet ordering them around, simply because such persons have been given the privilege by the state of practicing medicine (they are liable to add "upon them.") What they want is someone to han-

dle, in an efficient manner, particular problems that they find themselves plagued by. They want to know what such persons' real qualifications are and they don't want to be told they can have something "just as good" or a legal "equivalent," when they want a real Doctor of Medicine. Finally, they expect their attendant to be intelligent, industrious, efficient, and interested in *them*.

Flexner says that the principal arguments in favor of the use of "equivalency" in the days of the diploma mills were that this specious practice helped poor boys get a medical education and provided doctors for socially deprived areas. But "poor doctors are good enough for poor people" is not only factually baseless but absolutely unethical. A good medical student may be able to get by in a poor medical school, but an indifferent one requires expert instruction to achieve competence. Similarly, the demands made upon isolated rural or harassed slum doctors are so severe that such areas require the best talent it is possible to get. To conscript medical personnel for inner city practice would be a tacit admission that such practice is socially and professionally unacceptable and can only be sustained through conscription. Such a proposal is not only an insult to the poor as well as to the medical profession but it shirks the real responsibility of the state which is to provide a suitable mechanism and environment by means of which and in which good doctors can do the type of job they feel is really going to get proper results.

Consumer protection is difficult in the present condition of decompensated change which our whole society, as well as systems of medical care, is undergoing. Change produces disorientation and disorientation elicits impatient efforts to achieve homeostasis. Two easy homeostatic possibilities present themselves to political organizations during upheavals—a wait-and-see attitude or the seizure of every opportunity to confirm the power of the state. While the first policy makes no progress the latter may be regressive. A third, and more infrequently followed possible course, is that of integrated planning with a deliberate

distribution of power between those groups having legitimate interests in, and a practical working knowledge of the subject.

With the introduction of a plan for federal financial help for the indigent and aged sick, that segment of medical care formerly provided by the cities, states, and philanthropic organizations has offered these organizations opportunities to recoup finances, to expand services in a variety of sociologically oriented directions and to introduce the principle that the consumer rather than the physician may dictate what medical procedures shall be followed. While the proportion of physicians in the USA to the population at large has not changed greatly in the last half century (and is larger than in the UK and only slightly smaller than in the USSR) the rapid development of medical knowledge has placed greater demands upon the physician. These two circumstances, plus an almost total lack of integration between the services offered by hospitals, conflicting decisions by the courts, inconsistent legislative action, and confused operation of the State Boards' system of licensure, have made it impossible to utilize efficiently what medical manpower we have and have led to efforts to expand manpower by fiat rather than to gather the operational data necessary for proper planning. Moreover, when planning is attempted, it is obvious from the legislative experience in New Jersey, that little or no attention is paid to the opinion of the professionals. In view of the material presented here it should be clear to the consumer that the medical profession cannot reasonably be blamed for the current collapse of the system of delivery of medical care. Continued fragmentation of planning for medical care at the state level can only result in further dislocation of personnel. Furthermore, efforts to produce "a servile and overcontrolled profession cannot produce the best system of medical care." (Fry, *idem*, p. 230)

Proper protection of the consumer of health care requires standardization according to professional not political criteria, including adherence to uniform systems of evaluating

the credentials of physicians and for the accreditation of all medical service facilities,⁷ especially those operated by states and municipalities since these control the majority of hospital beds. Medical personnel should be designated according to their qualifications and in such a manner that the consumer will be able to determine what functions different persons in the system are actually authorized to perform. Reliable, official⁸ directories containing these data should be available for public inspection. It is not likely that the states' legislatures are currently any more ready to allow the federal government to develop a comprehensive national system of medical care than they have been to relinquish parochial attitudes in other areas but, until this becomes inevitable, there are still constructive steps which could be taken within the existing rickety framework. The public has to look to the professional expertise in its professional societies and medical schools, rather than to its legislators, in order to develop programs for the delivery of a satisfactory program of health care and for its protection within that system. If the legislature will begin by taking the necessary measures to support their state system of medical education they will have taken the first of a series of obviously necessary steps in the proper direction—i.e. doing what they can to provide properly trained, necessary personnel. The concern of our State Medical Society about the indifferent support the legislature has provided for medical education in this state was specifically expressed in Dr. Satulsky's official letter previously noted. If in addition, the legislature will support the schools in their efforts to provide adequate clinical services and programs of ongoing education in the community hospitals, some measure of confidence in the future of medicine in New Jersey may be restored. It is patently absurd to assert that health is a right and not a luxury and then to expect twentieth century medicine to function properly through nineteenth century political systems and in ill-equipped nineteenth century institutions.

The question the consumer has to decide, when he asks for top level medical care and is

looking for a Doctor of Medicine, is whether he will insist that the politicians do what the experts have told them must be done in order to obtain the genuine article or whether he will accept such substitutes which the legislature tells him are "equivalents" and "just as good."

Footnotes

1. In certain countries, systems of "folk medicine" are recognized forms of practice which are permissible (if witchcraft is not involved) and even registrable.

2. Many states predicate the licensure of physicians who have received training in foreign countries on the possession of a license to practice medicine in that country but seem to be unaware that there may be no such requirement. For example, in Britain, "No qualifications are required by law for the practice of medicine in this country. The nominal purpose of the statutory Medical Register, kept by the General Medical Council, is to enable patients to distinguish between 'qualified' and 'unqualified' practitioners." (Royal Commission on Medical Education, 1965-1968, 1968. Report, London, HMSO, paragraph 155). The entire concept of licensure may therefore be meaningless in a jurisdiction to which a State Board of Medical Examiners attempts to transfer its own concepts of the regulation of practice. In Britain several grades of physicians are tacitly acknowledged—distinctions which, in this country, are lost upon many State Boards of Medical Examiners.

3. We cannot here embark upon an inquiry into the differences between licensure, certification, registration, and accreditation.

4. The word *fraud* has a double meaning. In its common-sense meaning, fraud is deceitful action intended to take personal or material advantage of someone else, either by means of misrepresentation or failure to disclose what should have been disclosed. In its simplest sense this concept is expressed as misrepresentation. In a legal sense, however, nothing is fraud that has not been found so to be by a court. Misrepresentation implies not only an interchange between at least two people but requires a reasonable probability that one of the persons is misled. Extravagant claims are so common in advertising that such fraudulent behavior is often dismissed as "trade puffing" and of no real consequence, it being assumed that mature persons do not take such claims seriously. The same may be said of many medical quacks and cultists whose claims are obviously so transparent that only very gullible persons might be taken in by them. For this reason I consider the total danger from such unsophisticated pretensions to be less damaging to society in the aggregate than the subtle substitution of inferior products or services for the genuine articles. This is substantially the same position taken by the NJPOLS Commission on the issue of what areas of activity really demand licensure.

5. NJSR 45:9-8.1 became law in 1938 and is still on the books. This seems to present an opportunity for a person who has failed his course of medical training to become an intern and take care of patients for an aggregated period of 16 years in one of the approved hospitals of the state and then to present himself for licensure. It might be supposed that

nothing so odd could possibly happen but then how did such a law manage to get on the books?

6. The USA is a principal consumer of the immigrant product of educational establishments all over the world. In the case of medical education it is probably the principal consumer. ("If we knew how many of those who came as exchange visitors subsequently obtained waivers or spent two years in Canada and then reentered, it is likely that we would find that the foreign medical graduate program furnishes more doctors for the USA than it does for all the other countries of the world put together." This is from Millis, J. S., "The Foreign Medical Graduate," *J. Med. Education* (1971) 46:313-316). We have an educational balance-of-payments deficit far in excess of our fiscal shortage and the same principles are operative in both. In 1970 the US drain on foreign educational institutions was the largest in 20 years. In 1969, 2756 immigrant physicians were admitted but in 1970 the number rose to 3155. Asia supplied the largest number of these (1726) and the Philippines the largest number of Asiatics (769). New Jersey is a principal consumer of foreign-born physicians (187 in 1970). (Scientific Manpower Studies Group 1971, Science Resources Studies Highlights, NSF 71-11). This, in terms of immigrant physicians to population, ranks New Jersey with New York as the principal catchment for foreign physicians having major language communication problems. The reader is cautioned against the conclusion that this article equates the alien condition with undesirability or intellectual inferiority. What seems not to be apparent to most Americans is the fact that we have really very little insight into what other nationals may really be like. We admit that countries vary with regard to cultures, and that cultures vary greatly among themselves but something which may be admitted may still not be realized. What is very necessary in Mexico or the Philippines may be without value here and conversely. There is much to be learned in areas where "modern medicine" competes with "folk medicine." Anyone who has mastered the nuances of Cebuano *manamambal*, for example, is bound to look at medical problems in the US inner city from a completely different point of view from that which is sociologically current at the moment. There is a great deal to be learned from our foreign colleagues and one of the most important lessons is that patients and physicians of different cultures,

even when they are from the same nation, or of the same race, may simply not be able to work together in practically useful ways.

7. The phrase "service facilities" is employed here rather than "facilities for medical care" because, if the funds available for medical care are to continue to be preferentially expended for bed-bound patients it is toward a bed-oriented population that we are bound. One striking feature of the USSR system of medical care is the emphasis of its "health activists" on the prevention of disease by discouraging self-neglect and self-indulgence. There is a definite place for service facilities which are concerned with helping the public actively to maintain its health, rather than to take it for granted that the individual is going to be passively "cared for."

8. Specialty boards obtain *their* information (which may be erroneous) from the AMA, which is dependent for *its* information upon the State Board System and what the member says about himself. The AMA publishes a directory of its members which is the best reference source available to the public at present. The directories of the various state medical societies are generally very casual affairs.

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Pippin Hill

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The November Bond Issue

By Stanley S. Bergen, Jr., M.D., President, College of Medicine and Dentistry of New Jersey

When New Jersey voters go to the polls in November, they will be asked to approve a \$155 million 1971 Bond Issue to help continue, expand, and improve our New Jersey higher education system. As you think about the bond issue, your concerns will be numerous . . . the tax base, educational use of sales tax, and lottery money . . . important questions with complex answers that may obscure the real issue. At stake in November is the future of higher education and, in particular, the future of medical and dental education in New Jersey.

If partisan politics and narrow considerations can be set aside, the 1971 Bond Issue offers the voters of New Jersey the opportunity to say: "Yes. There is a future for medical and dental education in New Jersey."

On election day the voters of one of the most prosperous and populous states in the country must decide to respond positively to the aspirations of its youth for higher education and to the unquestionable need for the improvement of medical and dental education and the delivery of health care for every citizen. One set of figures alone shows that the medical and dental education needs of New Jersey are critical. The physician-patient ratio in New Jersey continues to be one of the lowest in this country, 130 to 100,000 population. Next door, in New York, they are doing much better. Their ratio is 230 to 100,000, and rising.

New Jersey youth are going out of state and overseas for their medical education. Even worse, most of these talented young men and women never return.

The rise of infant mortality, venereal disease, and lead poisoning all further underscore that the time for action in medical and dental education in New Jersey cannot be post-

poned to next year, or the year after that, but must be faced now.

The 1971 bond issue offers medical and dental education a continuation of the funding program begun in 1968 with a \$10.7 million share of that bond issue. Expenditure of the 1968 bond issue funds did not commence until recently, following the court decision in favor of the Newark Affirmative Action Program. On July 6, Governor Cahill, Senator Harrison Williams, Mayor Kenneth Gibson of Newark, and I shovelled a few pounds of symbolic earth from an empty lot in Newark's Central Ward to mark the breaking of ground for the new campus of the New Jersey School of Medicine—College of Medicine and Dentistry of New Jersey.

The first building under construction for the Newark campus is an \$8.5 million power plant. We are now seeking bids on the next phase of construction, the buildings that will house the library and the Dental School. In the months ahead we will also seek bids for the remainder of the construction.

The construction program for the College of Medicine and Dentistry, which the 1971 Bond Issue will help finance, will maintain and increase the momentum already shown by the dramatic expansion of enrollment now occurring in our medical and dental schools. The new facilities will enable the college to escalate the number of medical students in training from about 500 to more than 900 students by 1976. Similarly, the number of dental students will increase from about 200 to nearly 400 students. Most of these students can be expected to intern in New Jersey hospitals and/or practice in communities throughout the State.

Every voter has a stake in continuing medical and dental education. If New Jersey does not

have a strong continuing medical and dental education program, we cannot expect to attract outstanding American medical and dental school graduates to our state. Strong medical and dental schools are needed to develop quality continuing education programs and then see that they are successfully carried out. The College is presently working closely with The Medical Society of New Jersey, its component societies, and the Academy of Medicine in the development of quality continuing physician education programs.

On November 2, 1971 the voters of New Jersey can make the decision to build a medical and dental education complex equal to the needs of its citizens or to abandon them to the crowded academic health centers of neighboring states. In addition, there is increasing evidence that other state and private medical and dental schools give preference to residents of their own states, making it difficult for New Jersey residents to enter these schools. In some states, high out-of-state tuition rates are being used to discourage potential students. This means that New Jersey *must* take the responsibility for training a major share of its physicians and dentists. Every physician and dentist in New Jersey has the opportunity to share in building the College of Medicine and Dentistry of New Jersey by encouraging voters to go to the polls and vote YES for the 1971 Bond Issue for the sake of their own health and the future of higher education in New Jersey. Here are a few basic facts about the 1971 Bond Issue:

Fifty million dollars provided by the 1971 bond issue, together with federal grants, private funds, and loans, will permit the completion of two campuses for the College of Medicine and Dentistry of New Jersey through the development in Newark of a comprehensive medical and dental education complex and the construction in New Brunswick of a teaching hospital to complement the existing basic science building. The teaching hospitals at both campuses will be financed through self-liquidating loans as au-

thorized in recently-enacted amendments to the Educational Facilities Act. With these new facilities, the College will increase the number of medical students in training from about 400 to more than 900 students by 1976. Similarly, the number of dental students will increase from about 200 to nearly 400 students. Hospitals, through affiliations with the medical school, will receive the benefits of continuing medical education and research. Therefore, with the development of its two campuses, the College of Medicine and Dentistry will be able to play a forceful role in assuring a high-quality of health care to all the citizenry of the State.

This bond issue will allow \$21,900,000 expansion at the Newark, New Brunswick, and Camden campuses of Rutgers University.

In New Brunswick, the bond issue will bring about the expansion of the Douglass-Agriculture complex to allow a doubling of the current enrollment to 7,000 undergraduate students. Facilities planned for this campus include a library addition and expansion and renovation of existing buildings. Also included are funds for site development and support utilities, especially to service critically-needed student housing. The cost of constructing the new housing will be financed through the Educational Facilities Authority with the cost being met by student rental fees.

At Livingston College, an academic building is planned which will contribute significantly in moving this college to an enrollment of 5,000 students.

A field house is planned for University Heights which will provide a suitable and much-needed home for many of the University's athletic teams. The bond issue includes \$5 million towards the construction of this facility; the remaining funds will be solicited from alumni and other friends of the University.

At the Newark campus, facilities are planned

to provide for an undergraduate enrollment growth of 2,000 students, moving from a present enrollment of 5,000 to 7,000. The first phase of a physical education building will be constructed.

At the Camden campus, additional science facilities as well as renovation of existing structures will be provided. Total undergraduate enrollment will grow from the present total of 2,100 students to a level of 5,000 students.

The projected enrollments are dependent on the development for approximately 11,000 students of housing, student center, and other facilities currently not planned for construction with state funds.

State Colleges

The eight state colleges—Glassboro, Jersey City, Montclair, Newark, William Paterson, Ramapo, Stockton and Trenton—provide arts and sciences and professional programs at the baccalaureate level. These institutions are growing rapidly and providing a broad range of opportunities to the citizens of our state. In 1968 the state colleges enrolled 22,500 full-time undergraduate students. Presently, enrollment is 28,400. By 1975 (on the basis of this bond issue and facilities now under development), enrollment at the state colleges will exceed 45,000 full-time students.

The 1971 bond issue will provide funds to each established state college for essential alteration of existing facilities which will increase enrollments and improve the quality of education. At the two new state colleges—Ramapo and Stockton—the bond issue will support the construction at each college of facilities necessary to expand to an enrollment level of 3,000 full-time students.

In addition to these significant expansions of enrollments, the bond issue will support at Montclair, Newark, William Paterson, Ramapo, Stockton and Trenton site preparation for badly-needed student housing, the construction costs of which will be paid from fees charged to student occupants.

Community Colleges

The community colleges are the fastest growing segment of the state's higher education system. There are now fifteen community colleges in Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset and Union counties.

In 1968 full-time enrollment at the community colleges was 12,000 full-time students. Currently there are 24,500 students enrolled. By 1975, as the result of facilities now under development (plus new facilities to be supported by this bond issue) space for more than 41,000 full-time students is expected to be available.

This 1971 bond issue will support the construction of an academic complex for Essex County College. This new structure in downtown Newark will provide space for 6,100 full-time day students, an increase of more than 2,500 students from the present enrollment. The state's share for construction of this facility is \$10.1 million.

Funds are included for the first phase of the permanent academic facilities for Somerset County College. This college is currently housed in interim facilities located on the permanent site. These new permanent facilities will allow the college to expand its enrollment from 700 full-time day students to 2,300 students. The state's share of the cost of these new facilities is estimated to be \$4 million.

The remaining \$20 million provided by this bond issue will be allotted to the other community colleges in accordance with their priorities.

The 1971 bond issue is an investment in New Jersey's future. The benefits to be derived from this investment will be the decades of use to be provided by these facilities, and the years of productive service to be rendered by the graduates of our system of public higher education. This is an investment New Jersey needs to make.

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NEW JERSEY DOCTORS' NOTEBOOK

The Physician's Assistant — A Progress Report

(The following is abstracted from a report released by Malcolm C. Todd, M.D., Chairman of the AMA Council on Health Manpower.)

In 1969, the AMA House of Delegates adopted the Council on Health Manpower "Guidelines for the Development of New Health Occupations" to assist organizations and institutions contemplating the training and development of new health manpower. In 1970, the Council recommended to the Board of Trustees that the following be adopted as a working definition of the term "physician's assistant" or any other term that indicates a new health occupation with qualifications other than those of a licensed physician working in the capacity of an assistant to such a physician.

"The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

The Council on Health Manpower has also expressed its concern with the growing use of the term "physician's associate" to describe this new health occupation, and its recommendation that this term be used only to denote another physician was adopted by the House this year.

The American Academy of Orthopaedic Surgeons and the American Urological Association have completed surveys of their membership to corroborate need for a new type of assistant on their team and have developed detailed job descriptions for these new categories of health personnel. Based on this documentation, the Council on Health Manpower approved occupational guidelines for orthopaedic and urologic physician's assistants and invited both specialty groups to

work with the Council on Medical Education to develop criteria for the accreditation of educational programs. The Council on Medical Education has completed "Essentials for Approved Educational Programs for the Orthopaedic Physician's Assistant" and the drafting of "Essentials for the Urologic Physician's Assistant" is well under way.

In April 1971, the American Society of Internal Medicine, American Academy of Family Physicians, and the American College of Physicians jointly provided the Council on Health Manpower with a list of functions that would be delegated to assistants employed by primary physicians, especially internists and family or general physicians. The American Society of Internal Medicine and the American Academy of Family Physicians have also completed surveys to document the attitudes of their membership toward the physician's assistant.

The importance of these efforts becomes clear in light of the national need for increased numbers of skilled allied health workers, the desire to use the acquired skill and experience of returned military medical corpsmen, and the need for nationally recognized accreditation of programs in this new field to assure quality. Additionally, the Council on Health Manpower is exploring the feasibility of a mechanism for national certification of physician's assistants based upon proficiency examinations to provide alternative mechanisms for entry into the field and a greater assurance of personal qualifications of such personnel than are afforded through present systems of recognition.

The Council on Health Manpower, with legal assistance, has drafted answers to several specific questions forwarded to state agencies now attempting to establish regulatory mechanisms for physician's assistants. These questions and answers are listed below.

1. What is AMA's position on Boards of Medical Examiners' approving physician's assistant programs?

The AMA believes that California's A.B. 2109 offers an acceptable interim approach to the problem of program recognition. However, one of the distinctive features of American education is that the development and maintenance of educational standards has traditionally been the responsibility of non-governmental, voluntary accrediting agencies. Nationally recognized status of course would ideally involve approval by the AMA's Council on Medical Education.

2. What is AMA's position on Boards of Medical Examiners' approving doctors as preceptors?

The AMA would encourage the Board to implement a mechanism, as part of their program, which would qualify doctors to be responsible for a preceptorship program.

3. What recognition is to be given to physician's assistants?

The AMA is joined by the American Hospital Association, the American Public Health Association, and other national groups in calling for a moratorium on state licensure of any additional categories of allied health personnel to permit time for study of suggested alternatives to the present system, which is often restrictive to the evolution of the profession licensed, and which legally, often does not protect the public to the degree intended.

At present, the AMA favors national certification of physician support personnel and is considering a system for national certification of physician's assistants that could be based upon a uniform examination to evaluate individual qualifications.

4. Should Boards of Medical Examiners require some kind of proof that efforts have been made to determine the need for a physician's assistant?

Yes, the AMA has stated that documentation of need should be attested to by the group representing the potential employer, i.e., the medical specialty whose members will be responsible for utilizing new personnel. At the local level, we would recommend documentation to be in evidence to indicate that there are sufficient employment opportunities in the community to accommodate the graduates of a program. Additionally, such employment opportunities as exist should not be solely representative of one economic area, nor should they be primarily concentrated in the parent educational institution. Along these lines, documentation of need might be delegated to area-wide comprehensive health planning agencies.

5. How does AMA recommend physician's assistants be identified?

Our immediate concern is that this assistant be closely identified with a physician, but not mistaken for him. Accordingly, we have no objection to the term "physician's assistant" in the singular possessive, but the AMA's Council on Health Manpower has opposed use of the term "physician's associate" to identify anyone other than a fellow physician.

6. How does AMA recommend handling the question of informed consent?

The patient as a human being is entitled to choose his own physician and he should be permitted to acquiesce in or refuse to accept particular services from the physician to whom he grants his consent for treatment.

Customarily, patients have accepted the giving of injections by professional and vocational nurses, the drawing of blood specimens for diagnostic purposes by nurses and medical technologists, and a variety of routine procedures when performed by ancillary helpers of physicians. There are certain services that traditionally have been performed only by physicians, however. To change this traditional role and to have physicians suddenly delegate procedures, which patients impliedly consent to have performed only by the physician of their choice, to newly emerging categories of allied health personnel may expose physicians to increased legal problems and result in deteriorating medical public relations.

The profession has been advised to inform patients when assistants are to be used during surgical procedures, for example, and to make full disclosure if another physician is to perform such a procedure under the guidance of the primary physician. The same type of recommendation has been made to obstetricians who may be unavailable when a patient is in labor. Any substitution requires the consent of the patient who has agreed to have a particular physician perform certain procedures. In the case of physicians who plan to utilize physician's assistants in their office and/or hospital practice, the Office of the General Counsel recommends that the assistant be introduced and identified by role to all patients for whom he may provide services; that physicians not delegate any patient care functions to such an assistant when a patient indicates an unwillingness to have the function in question performed by anyone other than the physician; and that the physician be alert to patient complaints concerning the type or quality of services provided by such an assistant. This advice is based upon legal considerations and is designed to lessen the possibility of a patient suing the physician because of disappointment or dissatisfaction following a physician's failure fully to inform the patient of the role of the assistant. If a conscious patient accepts the services of a physician's assistant without objection, consent may be implied from the circumstances.

7. What are AMA recommendations regarding malpractice coverage?

The physician employer should obtain additional coverage for utilization of the assistant as deemed necessary by the insurer and seek to have the issue of professional liability clarified and established in all the settings where the assistant will function. This implies that in every instance there exists a clear understanding between the physician and his assistant as to the scope of the assistant's duties and responsibilities. Additionally, the assistant may wish to obtain his own professional liability insurance to protect his own interests.

8. What is the opinion of AMA regarding examination of the physician's assistant prior to certification?

The AMA would expect that interim efforts would be based upon assurances (examination) of their competency to perform within their defined scope of function.

9. *What is AMA's position regarding continuing education of physician's assistants?*

The AMA is on record as recommending continuing education for allied health personnel as well as for physicians.

10. *What is AMA's position on fees and charges in general?*

A statement drafted jointly by the AMA's Judicial Council and the Council on Medical Services, and approved by the House of Delegates, holds that when a physician assumes responsibility for services rendered to a patient by a resident or intern the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision. While this statement relates to interns and residents, it nonetheless recognizes the right of the physician to bill for services performed by others under his personal observation, direction, and supervision, when he is responsible for such services. It would seem that this opinion would control in the absence of any specific opinion of the Judicial Council or the House of Delegates relating specifically to the physician's assistant. Presently, there is no such specific ruling.

If the physician's assistant is a salaried employee acting under the direction and supervision of his or her physician employer, that employer would be expected to include cost for services rendered in his, the employers' fee. This is no new ethical concept, for example; nurses for years have in fact administered "shots," taken histories, and assisted the physician in a great variety of ways. The nurse was on salary. That salary—the cost of her services—became a component of the physician's fee. It was a part of his charge for the totality of the services rendered by him or under his direction or supervision. A salaried employee does not bill for his or

her services. An employer does not bill separately for the services performed by employees.

11. *What is AMA's position on charges that are made by institutions for physician's assistants who work in an emergency room?*

The question implies that a physician's assistant could be employed by a hospital to staff an emergency room and provide medical services. Since physician's assistants are not licensed to practice medicine and surgery, employment under these circumstances could subject both the hospital and the assistant to charges of the unlawful practice of medicine and invite increased exposure to legal liability.

In the event that a hospital employed a physician's assistant to make the initial evaluation of persons presenting themselves to the emergency room, and to notify the physician on call when medical services appeared necessary, the assistant would appear to be serving in the same role as any hospital employee and a separate charge would not be made for such services. The billing from the hospital would be for the use of the emergency room facilities and the hospital employees' usual services within the scope of their employment.

The physician's assistant who works in an emergency room, by definition, must be responsible to the doctor in charge; even though an employee of a hospital, this assistant must be accountable to a physician. We are vitally concerned about the employment and utilization of physician's assistants in emergency rooms across the country. While recognizing the theoretical economies of utilizing such personnel to handle trauma, we are especially concerned for the high incidence of triage judgment necessitated in such a setting. It is hoped that the medical staff of the hospital will continue to be responsible in this area.

Services to Rehabilitation Commission

From time to time, complaints are received from physicians concerning non-payment or late payment of bills for services rendered clients of the Rehabilitation Commission. Frequently, statements are sent directly to Trenton Central Office where they cannot be processed for lack of specific information. Physicians are advised that the invoice for payment for their services (Form SR-7) should be signed and returned to the *local District Office* within 30 days of receipt. Invoices not submitted within 30 days will result in additional delays.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of August.

	1971 August	1970 August
Aseptic Meningitis	48	53
Primary Encephalitis	2	3
Hepatitis: Total	364	303
Infectious	281	233
Serum	83	70
Malaria: Total	5	4
Military	2	3
Civilian	3	1
Meningococcal Meningitis	2	10
German measles	2	12
Measles	22	31
Salmonella	149	126
Shigella	36	23
Mumps	19	26

Shigella

Shigella has been the etiologic agent implicated in three outbreaks of diarrheal illness this summer. All three outbreaks have occurred in settings where large numbers of people were congregated—the first one in a summer camp, another in a nursing home, and the third in an institution for the mentally retarded.

Children at a New York summer camp became severely ill with nausea, vomiting, abdominal cramps, diarrhea, and fever 20 to 36 hours after visiting a camp in New Jersey. Sixty-two of 99 campers who had made the trip became ill. None of the New York campers who had avoided New Jersey became ill. Attack rates for foods which the New York campers had transported with them and for water drunk at the New Jersey camp clearly implicated the water as the responsible vehicle for transmission of the illness. Stool cultures from nine of the ill New York campers yielded *Shigella sonnei*. Children in the New Jersey camp did not experience a sudden outbreak of illness at the same time that the children from New York became ill. However, day by day analysis of gastrointestinal illness among New Jersey campers revealed that diarrhea had been a problem all summer with increased numbers of cases occurring

shortly after the arrival of each new group of campers. Water samples from the New Jersey camp demonstrated contamination by fecal coliforms and inadequate chlorination. These conditions have been rectified.

Shigella sonnei likewise caused an outbreak of diarrhea in a nursing home. Two patients with fever to 104, diarrhea, and positive stool cultures led to an epidemiologic investigation. Diarrhea began occurring in late July in one of two buildings housing patients. By mid-August, several patients in the other building also had diarrhea. Rectal swabs revealed that 80 of the 90 employees, plus 23 additional patients harbored *S. sonnei*, but all the employee's cultures were negative. About half of the infected patients had been totally asymptomatic, the others having diarrhea and low grade fever. The occurrence of cases over three to four weeks and the sequential spread of cases from one building to another probably indicates that the outbreak was propagated by person-to-person spread.

The third outbreak involved residents in three of 14 cottages at an institution for the mentally retarded. *Shigella flexneri* was probably introduced into the institution by an infected child transferred from another institution. Illness occurred in each cottage at separate times, suggesting spread from one cottage to another. Within each of the three cottages, 20 to 30 per cent of the residents became ill over a 4 to 5 day period indicating a common exposure. The vehicle by which the exposure occurred has not been determined, but was probably by either a child or an attendant.

Infected patients in the institution for the retarded and at the nursing home have been isolated and placed on antibiotics. Shigellosis, unlike gastrointestinal infections caused by salmonella, is usually terminated by appropriate antibiotic therapy. It is hoped that by treating all infected patients regardless of whether they have symptoms, the organism can be eradicated from institutions and thereby prevent the establishment of endemic shigellosis.

The Drug Efficacy Study

This fall, prescription labeling and promotional material on about 80 per cent of currently prescribed drugs will display a rating of the drug's efficacy for certain of the claimed indications. The action is being taken by FDA in the belief that the prescribing physician must know the scientific status of a given drug's efficacy in order to exercise the best possible clinical judgment in choosing drugs for patients. The following attempts to explain the aims and procedures of the National Academy of Sciences' Drug Efficacy Study (DESI) which led to this development.

The DESI program stems directly from requirements of the Federal Food, Drug, and Cosmetic Act. Beginning in 1938, this law required pre-clearance of new drugs by FDA for safety. The Drug Amendments of 1962 (Kefauver-Harris) required that effectiveness as well as safety of drugs be established prior to marketing. The amendment provided that this proof of efficacy be in the form of "substantial evidence." This evidence was defined by the Congress as ". . . adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience to evaluate the effectiveness of the drug involved, on the basis of which it could fairly and responsibly be concluded by such experts that the drug will have the effect it purports or is represented to have."

Therefore, since 1962, the FDA has reviewed all new drug applications for both safety and effectiveness. But the 1962 amendments also required that all drugs marketed between 1938 and 1962 and tested only for safety, now be evaluated for effectiveness as well. Some 4,000 drug products fell into this category and efficacy evaluation for all of them obviously posed an enormous task. To accomplish this task within a reasonable time, FDA went to the National Academy of Science for assistance. The Academy assembled 30 panels with some 200 medical and scientific specialists described in its 1969 report as "predomi-

nantly physicians with academic affiliations for the obvious reason that these best met the legal qualification of 'experts qualified by scientific training and experience to evaluate the effectiveness of the drug(s) involved.'"

The National Research Council—research arm of the National Academy of Sciences—developed guidelines for the study. In the course of its work, NRC consulted manufacturers, professional and scientific organizations, and other interested parties. The 30 study panels of the Academy considered information gathered from all these sources, including FDA files and the scientific literature. On the basis of this information, panel members were able to make informed judgments. The panels classified each of approximately 16,000 therapeutic claims for the more than 4,000 drug formulations into the following categories:

Effective: Substantial evidence of effectiveness;

Probably effective: Additional evidence required to rate the drug "effective;"

Possibly effective: While additional evidence for an "effective" rating might be forthcoming, as it stands there is little evidence of effectiveness, and in the absence of substantial evidence, the claim is considered inappropriate;

Ineffective: Lack of substantial evidence of efficacy;

Ineffective as a fixed combination: Even though one or more of the components might be effective if used alone, not acceptable in fixed dosage combination for reasons of safety or because of lack of evidence of contribution of each component to claimed effect; and

Effective but: With an appropriate qualification. This difficult group is under reconsideration by NAS/NRC and FDA.

Each drug received a rating. FDA was given the first rating report in October 1967; the last report in May 1969.

Significance to the Physician

The Efficacy Study revealed that about 60 per cent of all therapeutic claims reviewed lacked adequate evidence of efficacy under the law. The NAS experts reported a generally poor quality of labeling and of evidence submitted in support of efficacy claims. According to the FDA, many of the efficacy presentations sub-

mitted by manufacturers consisted of uncontrolled observations and "testimonial-type endorsements." There was a "conspicuous" lack of substantial evidence based on well-controlled investigations by experienced investigators, said FDA. The agency criticized the labeling of two-thirds of the drugs they evaluated. They found too many package inserts to be "poorly organized, repetitive, out of date, evasive, and promotionally oriented." The majority were found to fail in providing the physician and the pharmacist with authoritative and objective guides to prescribing or dispensing. This point takes on added significance because official labeling sets the boundaries for permissible advertising and other promotion.

FDA Response

In each case, FDA's conclusions, based on the NAS/NRC recommendations, are published in the *Federal Register*, an official journal of the Federal Government. As soon as the FDA judgment is published, manufacturers of drugs with claims rated less than effective have several options open to them short of product withdrawal. They may choose: (1) to develop necessary scientific data to substantiate current claims; (2) to eliminate or modify questionable claims; or (3) to reformulate the product.

When the choice is to develop additional data, the manufacturers have six months for "possibly effective" claims and twelve months for "probably effective" claims. During these periods, manufacturers may request extension of time based on development of a satisfactory protocol for study of disputed claims. The drug may remain on the market in the interim if there are no questions of safety. FDA is well aware that the studies will take time and will not insist on unreasonable time limits in any case.

Over-all, the Agency says it will better meet the need to reach practicing physicians and other professionals with information on what is being proposed and accomplished under the drug efficacy program. The law requires

that the labeling of prescription drugs bear full disclosure of all material facts to the prescribing physician. On the basis of this double incentive, FDA is issuing regulations requiring that all labeling and all promotional material carry a prominently placed "box" characterizing the claims for any given drug which has been judged "probably" or "possibly" effective.

FDA recognizes that drugs of questioned efficacy will be available by prescription while evidence of effectiveness is still incomplete. Such a status will be temporary, and drugs in this category either will become "effective" as soon as appropriate evidence permits, or removed from the market if this evidence is not forthcoming. The Drug Efficacy Study, says the FDA, has been the most thorough review ever attempted of drugs available to the physician. When the study is fully implemented, the physician should be able to prescribe any marketed drug, secure in the knowledge that its efficacy has been judged on the basis of acceptable scientific evidence.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—A. Bhattacharyya, M.D., 15, West Erie Street, Albany, New York 12208. University of Calcutta (India) 1954. Board eligible. Group, partnership, salaried. Available January 1972.

Kin Siu Tam, M.D., 320 East North Avenue, Pittsburgh, Pennsylvania 15212. South China Medical College 1958. Hospital. Available July 1972.

CARDIO-THORACIC SURGERY—F. I. Ehrenstein, M.D., U. S. Naval Hospital Memphis, Millington, Tennessee 38053. Istanbul 1962. Board certified. Partnership, solo. Available March 1972.

DERMATOLOGY—Charles Wasilewski, M.D., 844 South Lincoln Avenue, Springfield, Illinois 62704. Jefferson 1963. Board certified. Group. Available July 1971.

FAMILY PRACTICE—Louis S. Zeiger, M.D., 415 Queen Anne Road, Cherry Hill, New Jersey 08034. University of Pennsylvania 1967. Group or partnership, but not solo. Available September 1971.

GENERAL PRACTICE—Michael F. O'Connor, M.D., 15,520 Windmill Pointe Drive, Grosse Pointe Park, Michigan 48230. University College, Cork, Ireland 1970. Solo. Early 1972.

INTERNAL MEDICINE—Barry A. Portnoy, M.D., 8008 Seawall Blvd., Galveston, Texas 77550. Emory 1966. Board eligible. Group. Available July 1972.

M. M. Rahman, M.D., 275 Bay 37 Street, Brooklyn, New York 11214. Dacca Medical (Pakistan) 1958. Board eligible. Group, partnership, or institution. Available July 1971.

Eugene F. Cheslock, M.D., 107 Beverwyck Drive, Gunderland, New York 12084. CMDNJ 1965. Subspecialty, Hematology. Board eligible. Group. Available July 1972.

Nicholas A. Cannarozzi, M.D., 1 Hemlock Hill Road, Clinton, Connecticut 06413. Hahemann 1965. Board eligible. Subspecialty, Rheumatology. Association, partnership, or solo. Available July 1972.

Edward J. Feller, M.D., 4287-1 Wilmington Drive, Andrews AFB, Washington, D.C. 20331. State University of New York 1965. Board certified. Subspecialty Gastroenterology. Partnership, group, or hospital-based. Available, summer of 1972.

OBSTETRICS AND GYNECOLOGY—Teresita M. Gungon, M.D., 9316 Seaview Avenue, Brooklyn, New York 11236. Santo Tomas, 1961. Board eligible. Full-time hospital, group, or partnership. Available August 1971.

Vellore Bhupathy, M.D., 802 Gaston Avenue, Fairmont, West Virginia 26554. Bangalore (India) 1961. Board eligible. Group, partnership, institution, or solo. Available.

Shi-Han Oh, M.D., 13-C Concord Cove Apts., Havre De Grace, Maryland 21078. Seoul University (Korea) 1960. Board eligible. Group or partnership. Available January 1972.

OPHTHALMOLOGY—Robert A. D'Iorio, M.D., 8 Whittier Pl., Apt. 22F, Boston 02114. Georgetown 1965. Board eligible. Partnership or group or solo. Available March 1972.

John H. Park, M.D., 741 South Gunderson Avenue, Oak Park, Illinois 60304. State University of New York 1966. Partnership or solo. Available January 1972.

ORTHOPEDIC SURGERY—Jalal Sadrieh, M.D., 430 East 67th Street, New York 10021. Pahlavi (Iran) 1962. Board eligible. Solo, partnership, or group. Available January 1972.

PATHOLOGY—John S. Weinstein, M.D., 123 York Street, Apt. 11-D, New Haven, Connecticut, New Jersey College of Medicine 1966. Board eligible. Any type of practice. Available July 1972.

Joseph W. Placer, M.D., 130th Station Hospital, APO, New York 09102, New York Medical 1964. Board certified. Group, partnership, or institution. Available September 1972.

PEDIATRICS—U. K. Kim, M.D., 94 Hillcrest Drive, Victor, New York 14564. Ewha (Korea) 1957. Board eligible. Institutional, such as college health center, or public health field. Available September 1971.

Kalavathi Bhupathy, M.D., 802 Gaston Avenue, Fairmont, West Virginia 26554. Bangalore (India) 1961. Board certified. Group, partnership, clinic, or institution. Available.

PHYSICAL MEDICINE AND REHABILITATION—Pravin Panchal, M.D., 2441 Webb Avenue, Apt. 5A, Bronx, New York 10468. Gujarat University (India) 1965. Board eligible. Hospital. Available July 1971.

RADIOLOGY—M. A. Jafarzadeh, M.D., 314 West 56th Street, Apt. 4B, New York 10019. Tehran 1956. Board eligible. Partnership, group, or hospital. Available April 1972.

SURGERY—Nemesio M. Elefante, M.D., 18724 Walkers Choice Road, Apt. 2, Gaithersburg, Maryland 20760. Santo Tomas (Philippines) 1959. Board eligible. Solo, group, or partnership. Available July 1971.

Abolfath B. Ardalan, M.D., 12300 McCracken Road, Cleveland, Ohio 44125. Tehran (Iran) 1962. Subspecialty, thoracic and vascular surgery. Board eligible. Group or partnership. Available July 1971.

Benjamin C. Agustin, M.D., 9316 Seaview Avenue, Brooklyn, New York 11236. Santo Tomas 1960. Board eligible. Full-time hospital, partnership, or group. Available August 1971.

Sun Jiang Guo, M.D., Western Massachusetts Hospital, 91 East Mountain Road, Westfield, Massachusetts 01085. Taiwan University 1964. Board eligible. Associate or hospital-based. Available July 1972.

Charles P. Carroll, M.D., 5011 Caryn Court, Apt. 303, Alexandria, Virginia 22312. New York University 1965. Board eligible. Available July 1972.

UROLOGY—M. A. Fermaglich, M.D., Munson Army Hospital, Fort Leavenworth, Kansas 66027. Brussels 1964. Solo, partnership, or group. Available October 1971.

Moustafa S. Naguib, M.D., 1325 South Grand Avenue, St. Louis, Missouri 63104. Ein Shams University (Cairo) 1961. Board eligible. Solo, associate, or group. Available July 1971.

Shah M. Chaudhry, M.D., 102 North Main Street, Cape May Court House, New Jersey 08210. Punjab University (Pakistan) 1956. Board eligible. Group or partnership. Available July 1971.

R. M. Ravavarapu, M.D., 20 Fairhaven Boulevard, Woodbury, New York 11797. Guntur (Andhra, India) 1963. Group, partnership, or solo. Available.

A. Turhan Ilkay, M.D., 22 Fairhaven Boulevard, Woodbury, New York 11797. Istanbul (Turkey) 1951. Board eligible. Any type of practice. Available.

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1. Gordon, E. E. and Haas, A., *Indust. Med. & Surg.* 28:217, May, 1959.



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ANNOUNCEMENTS

Colloquium on Alcoholism

The second Annual Meeting of the American Medical Society on Alcoholism—"Multi-disciplinary Treatment of Alcoholism—The Changing Role of the Physician and the Allied Health Professions"—will be held on October 29 and 30 in the Turner Auditorium of the Johns Hopkins University School of Medicine, Baltimore, Maryland.

In addition to innovative papers by outstanding authorities in the field, workshops will consider such problems as children alcoholics, the family, medical complications, the woman alcoholic, planning alcoholism programs, traffic safety, industrial programs, the general hospital, other drug abuse, and the role of non-professionals. Further information may be secured from the Director, Division of Alcoholism Control, State Office Building, 301 West Preston Street, Baltimore, Maryland 21201.

Clinical Application of Basic Sciences

In the "Clinical Application of Basic Sciences" series offered by the Burlington County Memorial Hospital, the following programs have been announced for November. Credit will be allowed (1½ points per session) by the American Academy of General Practice.

November 4 Cranio-Cerebral Trauma
November 11 Crushing Injuries of the Chest
November 18 Peritoneal Dialysis in the Community Hospital

Meetings convene promptly at 3:30 p.m. in the Common Room of the T. J. Summey Building. Additional information may be obtained from the Department of Medical Education of the hospital, which is located at 175 Madison Avenue, Mount Holly 08060—telephone (609) 267-0700.

Seminar for Emergency Department Personnel

On November 3 and 4, a symposium will be held in Cherry Hill for emergency department personnel. The program covers a review of all aspects of emergency room care, including resuscitation, wounds, x-ray problems, electrocardiography, triage, new equipment, staffing, and even public relations. Sponsoring agency is the New Jersey Committee on Trauma of the American College of Surgeons. The \$40 registration fee includes luncheon, programs, parking fees, and packets of lecture notes. For more information, write to Herbert MacNeal, M.D., St. Clare's Hospital, Denville 07834.

Guide to Prescription Prices

Now available at \$7.95 is a physician's Guide to Prescription Prices. It is released by Wilcom, Ltd., 6900 East Genessee Street, Fayetteville, New York, 13066. Drugs are listed alphabetically by trade name and the average price which the patient may expect to pay per dosage unit is also shown. The text includes a "Medical Almanac" which covers conversion tables, growth chart, emergency numbers for poison control centers, and essential medical and prescribing data. The average prices for generic drugs are also included. The book is revised semi-annually. The volume is intended for physicians and not for patients, and the average prices are obtained by computer calculations based on the pricing practices of typical drug stores throughout the United States. Experience indicates that there is very little geographical variation in these prices.

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MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1971

October

- 10 Academy of Medicine of New Jersey,
New Jersey and New York Dental So-
cieties of Anesthesiology, American
Society of Advancement of Anesthesia
in Dentistry, and CMDNJ
Martland Medical Center, Newark
Amnesia, Sedation, and Anesthesia in Ambu-
latory Dental Patients
- 13 Academy of Medicine of New Jersey
Urology Section Meeting
- 13 American Academy of Pediatrics (New
Jersey Chapter)
Nurses' Residence, United Hospitals
Medical Center, Newark
Child Health Care in Newark
- 13 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Kidney Functions
- 14 Burlington County Memorial Hospital
Mount Holly
Masked Depression in Medical Practice
- 18 Academy of Medicine of New Jersey
Beth Israel Medical Center, Newark
Disorders of the Heart Beat
- 19 Associated Eye Residencies of New
Jersey
Eye Institute of New Jersey, Newark
Phaco-Emulsification
- 20 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Recurrent Fevers of Unknown Etiology
- 21 Burlington County Memorial Hospital
Mount Holly
The Influence of Language upon Symptoma-
tology in Foreign-born Patients
- 25-29 Saint Barnabas Medical Center
Livingston
Obstetric and Gynecologic Pathology

27 St. Clare's and Dover General Hos-
pitals

Cancer Chemotherapy and Immunotherapy

27 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Hospital Acquired Infections

28 Burlington County Memorial Hospital
Mount Holly
Unusual Post Surgical Pain

November

3, 10, Academy of Medicine of New Jersey
17 Beth Israel Medical Center, Newark
Implantation with Permanent Pacing

3-4 New Jersey Committee on Trauma
(ACS)
Cherry Hill Inn, Cherry Hill
Emergency Department Personnel

4 Burlington County Memorial Hospital
Mount Holly
Cranio-Cerebral Trauma

10 Academy of Medicine of New Jersey
St. Michael's Medical Center, Newark
Psychiatry Symposium

10 St. Clare's and Dover General Hospi-
tals
Leukemia and Chemotherapy

10 New Jersey Dental Association
Semi-Annual Session

10 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Chronic Renal Disease and Dialysis

10 Academy of Medicine of New Jersey
Hoffmann-La Roche, Nutley
Alcoholism

11 Burlington County Memorial Hospital
Mount Holly
Crushing Injuries of the Chest

- 17 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Pharmacology of Diuretics, Indications and Use
- 18 Burlington County Memorial Hospital
Mount Holly
Peritoneal Dialysis in the Community Hospital
- 24 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Electrolyte Imbalance
- 24 St. Clare's and Dover General Hospitals
Lymphomas

December

- 1 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Urology, Including Prostatic Disease
- 2-3 Saint Barnabas Medical Center
Livingston
Gynecological Endoscopy
- 2 Burlington County Memorial Hospital
Interservice Seminar
- 8 St. Clare's and Dover General Hospitals
Arteriograms and Lymphangiograms
- 8 Academy of Medicine of New Jersey
Saint Michael's Medical Center,
Newark
Urinary Tract Infections
- 8 Academy of Medicine of New Jersey
Bergen Pines Hospital
Paramus
Pacemaker; Electrode and Vascular Surgery
- 9 Burlington County Memorial Hospital
Mount Holly
The Management of Suspected Testicular Neoplasm
- 11 Academy of Medicine of New Jersey
Bloomfield
Section on Dermatology
- 16 Burlington County Memorial Hospital
Mount Holly
Medical and Surgical Management of Urolithiasis

- 22 St. Clare's and Dover General Hospitals
Metastatic Disease of the Breast
- 30 Burlington County Memorial Hospital
Mount Holly
Evaluation and Management of the Arthritic Hip

1972 January

- 6 Burlington County Memorial Hospital
Mount Holly
Viral Hepatitis: A Reappraisal of Mild Hypertension
- 11 Academy of Medicine of New Jersey
Bloomfield
Sectional Meeting: Dermatology
- 13 Burlington County Memorial Hospital
Mount Holly
Current Concepts of Cardiomyopathy
- 19 Academy of Medicine of New Jersey
College of Medicine and Dentistry at
Newark
Advances in Radiotherapy
- 20 Burlington County Memorial Hospital
Mount Holly
Current Trends in the Therapy of Mild Hypertension
- 26 St. Clare's and Dover General Hospitals
Fluid and Electrolyte Balance
- 27 Burlington County Memorial Hospital
Mount Holly
Orthostatic Hypotension

February

- 3 Burlington County Memorial Hospital
Mount Holly
Problems Related to Antidiuretic Hormones
- 9 St. Clare's and Dover General Hospitals
Renal Failure
- 10 Burlington County Memorial Hospital
Mount Holly
Neurological Complications of Visceral Carcinoma
- 17 Burlington County Memorial Hospital
Mount Holly
Full Time and Voluntary Staff—The Interface

- 23 St. Clare's and Dover General Hospitals
Auto-immune Aspects plus Transplantation
- 24 Burlington County Memorial Hospital
Mount Holly
Newer Approaches to Community Health

March

- 2 Burlington County Memorial Hospital
Mount Holly
Sterilization and Therapeutic Abortion
- 8 St. Clare's and Dover General Hospitals
Renal Vascular Hypertension; Malignant Hypertension
- 9 Burlington County Memorial Hospital
Mount Holly
Family Life Problems in Medicine
- 16 Burlington County Memorial Hospital
Mount Holly
Geriatric Psychiatry
- 22 St. Clare's and Dover General Hospitals
Secondary Nephropathies
- 23 Burlington County Memorial Hospital
Mount Holly
Alcohol: The Unglamorous Addiction
- 30 Burlington County Memorial Hospital
Mount Holly
Descent into Hell

April

- 6 Burlington County Memorial Hospital
Mount Holly
Interservice Seminar
- 12 Academy of Medicine of New Jersey
Veterans Administration Hospital, East Orange
Dental Symposium: Implantology
- 13 Burlington County Memorial Hospital
Mount Holly
Thermography
- 20 Burlington County Memorial Hospital
Mount Holly
Radiography in Evaluation of Gastrointestinal Diseases
- 27 Burlington County Memorial Hospital
Mount Holly
Diseases of the Esophagus

May

- 4 Burlington County Memorial Hospital
Mount Holly
Syndrome of Stress Ulcer
- 6-9 The Medical Society of New Jersey
Haddon Hall, Atlantic City
Annual Meeting
- 11 Burlington County Memorial Hospital
Mount Holly
Zollinger-Ellison Syndrome

1972 Annual Meeting Dates—May 6-9

The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance

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35 yrs 291-2		Ordered By Dr Goldstein		Prior Antibiotic Treatment																																			
I. PYOGENS <input type="checkbox"/> SMEAR OR MICRO <input checked="" type="checkbox"/> CULTURE		Specimen - (Source) <i>sputum</i>		(FOR LAB USE ONLY)																																			
II. ACID FAST BACILLI <input type="checkbox"/> SMEAR <input type="checkbox"/> CULTURE		Report <i>An abundance of Pseudomonas</i> <i>Aeruginosa grew</i> <i>(pure culture)</i>		Date Report Made By 7/21/71 CE.																																			
III. FUNGI <input type="checkbox"/> SMEAR <input type="checkbox"/> CULTURE																																							
BACTERIOLOGY																																							

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PRESCRIBING INFORMATION **Indications:** Primarily for treatment of infections due to susceptible strains of *Pseudomonas aeruginosa*, *Proteus* species (particularly indole-positive strains), and certain *Escherichia coli*. Clinical effectiveness has been demonstrated in the following infections when due to these organisms: Urinary tract infections; severe systemic infections and septicemia; acute and chronic respiratory infections (while clinical improvement has been shown, bacteriologic cures cannot be expected in patients with chronic respiratory disease and cystic fibrosis); soft tissue infections. Although PYOPEN (disodium carbenicillin) is indicated primarily in Gram-negative infections, its activity against Gram-positive organisms should be kept in mind when both Gram-positive and Gram-negative organisms are isolated (see Actions). **Note:** During therapy, sensitivity testing should be repeated frequently to detect the possible emergence of resistant organisms. **Actions:** Organisms found to be susceptible *in vitro* include: **Gram-Negative Organisms**—*Ps. aeruginosa*, *Proteus mirabilis*, *Pr. morganii*, *Pr. rettgeri*, *Pr. vulgaris*, *E. coli*, *Enterobacter* species, *Salmonella* species, *Hemophilus influenzae*, and *Neisseria* species. **Gram-Positive Organisms**—*Staphylococcus aureus* (nonpenicillinase-producing), *Staph. albus*, *Diplococcus pneumoniae*, Beta-hemolytic streptococci, and *Streptococcus faecalis*. Some newly emerging pathogenic strains of *Herellea*, *Mima*, *Citrobacter*, and *Serratia* have also shown *in vitro* susceptibility. Not stable in the presence of penicillinase. *Klebsiella* species are resistant. Some strains of *Pseudomonas* have developed resistance fairly rapidly. **Contraindications:** Known penicillin allergy. **Warnings:** Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, appropriate therapy should be instituted and discontinuance of disodium carbenicillin therapy considered, unless the infection is life threatening and only amenable to disodium carbenicillin therapy. The usual agents (antihistamines, pressor amines, and corticosteroids) should be readily available. **Usage in Pregnancy:** Safety for use in pregnancy has not been established. **Precautions:** As with any other potent agent, it is advisable to check periodically for organ-system dysfunction, including renal, hepatic, and hematopoietic systems, during prolonged therapy. Emergence of resistant organisms, such as *Klebsiella* species and *Serratia* species, which may cause superinfection, should be kept in mind. Each gram contains 4.7 mEq sodium; in patients where sodium restriction is necessary, such as cardiac patients, periodic electrolyte determinations and monitoring of cardiac status should be made. Observe patients with renal impairment for bleeding manifestations and adhere strictly to dosage recommendations. If bleeding manifestations appear, discontinue antibiotic and institute appropriate therapy. As with any penicillin preparation, the possibility of an allergic response, including anaphylaxis, may occur, particularly in a hypersensitive individual. **Administration:** Intramuscular injections should be made well within the body of a relatively large muscle (not into the lower and mid-third of the upper arm), and aspiration is necessary to help avoid inadvertent injection into a blood vessel. May be given by either intravenous injection or intravenous infusion. After reconstitution with Sterile Water for Injection unused portions should be discarded after 24 hours if stored at room temperature, or after 72 hours if refrigerated. **Adverse Reactions:** **Hypersensitivity Reactions**—Skin rashes, eosinophilia, pruritus, urticaria, drug fever, and anaphylactic reactions. **Gastrointestinal Disturbances**—Nausea. **Hemic and Lymphatic Systems**—Hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, in uremic patients receiving high doses (24 gm/day), hemorrhagic manifestations associated with abnormalities of coagulation tests, such as clotting and prothrombin time. **Hepatic and Renal Studies**—SGOT and SGPT elevations have been observed, particularly in children. To date, no clinical manifestations of renal disorders have been demonstrated. **Central Nervous System**—Convulsions or neuromuscular irritability could occur with excessively high serum levels. **Local Reactions**—Pain at the site of injection, sometimes accompanied by induration, Vein Irritation and Thrombophlebitis—particularly when undiluted solution is injected directly into the vein. **How Supplied:** Available in 1 Gm. and 5 Gm. vials.

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OBITUARIES

Dr. Abraham G. Chmelnik

Most residents of Essex County will remember with affection, Abraham G. Chmelnik, M.D., who was a pioneer anesthesiologist with the Newark City Hospital. Born in 1899, he was 72 years old at the time of his death on July 12, 1971. Dr. Chmelnik had a tour of duty as Medical Director of the Martland Medical Center, and was active in the affairs of the American Society of Anesthesiologists. He was a 1922 alumnus of the Medical School at New York University. During World War II, Dr. Chmelnik was a Commander in the Medical Corps. of the U. S. Navy.

Dr. R. John Cottone

A long illness caused the death of R. John Cottone, M.D. on August 4, 1971, at the age of 75. Dr. Cottone was a well-known Mercer County surgeon and was, at one time, president of the Mercer County Medical Society. He earned his M.D. at the Medical School of Georgetown University in 1923 and, during his active surgical career in Trenton, he was identified with the St. Francis Hospital.

Dr. Hayward F. Day

Formerly president of the Board of Health of Somerset, New Jersey, Hayward F. Day, M.D., died on June 22, 1971, at the age of 65. A Bellevue graduate, class of 1933, Dr. Day was active in school medicine for many years. He was a long-term member of the New Jersey School Physicians Association, and had been identified with the Runnells Hospital in Berkeley Heights and the Muhlenberg Hospital in Plainfield.

Dr. Jacob S. Freedman

Born in 1906, Jacob S. Freedman, M.D. died on August 7, 1971 at the age of 65. He was a Bellevue graduate, in the class of 1930, and he

served the people of Passaic County ever since he left medical school. He was attending in surgery at the Beth Israel Hospital of Passaic and also at the Preakness Hospital in Paterson. Dr. Freedman was active in committee work for the Passaic County Medical Society and was a Fellow of the American College of Surgeons.

Dr. Bernard Gartlan

Bernard Gartlan, M.D., Chief of the Department of Anesthesiology at the Community Memorial Hospital in Toms River died on July 26, 1971 at the age of 58. He was a 1938 graduate of Georgetown and had been on the staff of the Paul Kimball Hospital in Lakewood before coming to Toms River. He was an active member of the New Jersey Association of Anesthetics and a leader in Boy Scout work. During World War II, he was a Lieutenant in the Medical Corps of the Army of the United States.

Dr. Peter J. Gianquinto

Director of Radiology at St. Barnabas Hospital in Livingston, Peter J. Gianquinto, M.D., died on July 2, 1971, at the age of 59. Dr. Gianquinto received his medical degree at Long Island College Hospital in 1937 and early in his career joined the staff of the St. Barnabas Hospital. He was board certified in radiology and was a Fellow of the American College of Radiologists. He was the consultant in his specialty at the Kessler Institute in West Orange.

Dr. Earl J. Halligan

Hudson County practitioners were well acquainted with Earl J. Halligan, M.D., who was active in medical affairs in his county for over half a century. Born in 1893, he was graduated at Bellevue in 1914. He was Medical Director of St. Francis Hospital and was on the staff at Margaret Hague Hospital, the Pollak Hospital, and the Jersey City Medical Center. He was a Fellow of the American College of Surgeons and a member of the New Jersey Society of Surgeons.

Dr. David Izenberg

David Izenberg, M.D., a Jefferson graduate, class of 1929, died on July 11, 1971. He was an obstetrician and gynecologist and for thirty years served on the staff of the Barnert Memorial Hospital in Paterson. He was identified with the American Academy of Obstetrics and Gynecology. Dr. Izenberg was 68 years old at the time of his death.

Dr. W. Franklin Keim

One of New Jersey's pioneer head and neck surgeons, W. Franklin Keim, M.D., died on July 8, 1971, at the untimely age of 61. He received his M.D. at Columbia University College of Physicians and Surgeons in 1935. Dr. Keim was board certified in otology and laryngology. He was on the staff of most of the hospitals in Essex County and was also a Fellow of the American College of Surgeons. Dr. Keim was a major force in the development of the Academy of Medicine of New Jersey and served for some years as its president. He was also a Fellow of the American Academy of Ophthalmology and Otolaryngology. He was president of the medical staff at Mountainside Hospital in Montclair at the time of his death.

Dr. Israel Levine

Israel Levine, M.D., born in 1894, was 87 years old at the time of his death on March 17, 1971. A 1919 graduate of Bellevue Hospital, Dr. Levine was a family physician of the old school and served the people of Hudson County for over half a century. He was identified with the Jersey City Medical Center, the Fairmount Hospital, and the Margaret Hague Maternity Hospital.

Dr. Virginius D. Mattia

The death of Virginius D. Mattia, M.D. at the age of 48, was a shock to his many friends in northern New Jersey. He held a major executive position with Hoffmann-LaRoche, and for years had been in the field of clinical and pharmacological research, coming to

Hoffmann-LaRoche from a similar position with Merck. His special field was cardiology. Dr. Mattia was born in 1923 and became a M.D. at Bellevue in 1950. He died unexpectedly on July 4, 1971.

Dr. Cesare Milano

A half-century of practice in southern New Jersey came to an end on July 9, 1971, with the death that day of Cesare Milano, M.D. Born in Italy in 1889, he was 82 years old at the time of his death. He was a 1914 alumnus of the medical school at Naples, and was a medical officer in the Italian Army during World War I. In 1921, he came to the USA and practiced in Newark until 1924, when he moved to Atlantic City. He was a laureate of our Golden Merit Award in 1964, and was an active member of the Atlantic County Medical Society.

Dr. John J. O'Connor, Jr.

At the untimely age of 47, John J. O'Connor, Jr., M.D., a member of our Hudson County component, died on July 17, after a long illness. He was a 1948 graduate of Long Island Medical College. He did graduate work in urology and soon became board certified in that specialty. Dr. O'Connor was Director of the Urology Department at St. Mary's Hospital in Hoboken and attending urologist at St. Francis Hospital in Jersey City and Holy Name Hospital in Teaneck. He was a Fellow of the American College of Surgeons and a member of the New Jersey Society of Surgeons and of the American Urology Association.

Dr. George C. Parell

Born in 1911, George C. Parell, M.D., died unexpectedly on July 16, 1971, at the age of 60. He was a general practitioner with a special interest in proctology and was identified with St. James and St. Michael's Hospitals in Newark. Dr. Parell earned his M.D. degree at Georgetown University in 1936. During World War II he was a Captain in the Medical Corps of the U. S. Army.

Dr. Harry T. Rachlin

Harry T. Rachlin, M.D., died on January 13, 1971, at the age of 62. He was an internist, active in civic affairs in Irvington, and on the staff of the Irvington General Hospital. He was a 1935 graduate of Glasgow University in Scotland. During World War II he was a Major in the Medical Corps of the Army of the United States.

Dr. Daniel Ross

Residents of Middlesex County were shocked to learn, on July 31, 1971, of the death of Daniel Ross, M.D., at the age of 50. Dr. Ross, a pediatrician, was graduated from the Medical School of the University of Virginia in 1946 and was on the pediatric staff of both hospitals in New Brunswick. From 1948 to 1951 he was a Captain in the Medical Corps of the Army of the United States.

Dr. Joseph G. Sutton

One of the leading psychiatric administrators of the country, Joseph Guy Sutton, M.D., died on August 3 at the age of 78. He was a graduate of the medical school at Vanderbilt University, class of 1922, and began his career in psychiatric hospital administration at the Tennessee State Hospital in Nashville. He later came to New Jersey as assistant physician at the Essex County Hospital Center, then called the Essex County Overbrook Hospital, and assumed positions of increasing responsibility, culminating in his appointment as Superintendent and Medical Director in 1948. He retired in 1957, becoming a consultant in private practice in psychiatry.

Dr. Sutton was a Fellow of the American Psychiatric Association, and was accoladed as the leader of New Jersey psychiatry when he became President of the New Jersey Neuropsychiatric Association. He was a pioneer in community psychiatry in our state and was proud of the fact that under his administration Overbrook became, as it has remained, an institution without walls.

Dr. Donald J. Volpe

Born in 1914, Donald J. Volpe, M.D., died on June 23, 1971 at the untimely age of 57. He was a 1939 Hahnemann graduate who practiced in the Hammonton area for 30 years. He was active in the American Academy of General Practice and was affiliated with the Kessler Memorial Hospital. He had a tour of service with the Hammonton Board of Education. During World War II, he was a Lieutenant Commander in the Navy of the United States.

Dr. Charles F. Voorhis

On August 5, 1971, Charles F. Voorhis, M.D., died at the grand age of 79. Dr. Voorhis was a pioneer in otolaryngology. He was a 1913 graduate of Hahnemann and practiced in Palmyra until his retirement to Surf City in 1965. Dr. Voorhis was an active member of the Burlington County Medical Society and for many years he was on the staff of the West Jersey Hospital in Camden.

Dr. Joseph H. Wyatt

One of the pioneers of radiology in this country, Joseph H. Wyatt, M.D., died on June 24, 1971, at the age of 84. He was a member of the famous class of 1917 at Jefferson Medical College. He was an early radiologist at the West Hudson Hospital in Kearny. Dr. Wyatt was board certified in his chosen specialty and was also active in the Radiology Society of North America. He was a resident of Sussex County at the time of his death.

Dr. Henry F. Zangara

Born in 1918, Henry F. Zangara, M.D., died on July 27, 1971, at the untimely age of 53. He was a board certified radiologist and a member of the New Jersey Radiology Society. He was chief of the X-ray Department at St. Peter's Hospital in New Brunswick. He was active in the affairs of the Middlesex County Medical Society and served during World War II as a Captain in the Medical Corps of the Army of the United States.

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BOOK REVIEWS

Clinical Approach to Endocrine Problems in Children,

Matthew M. Steiner, M.D., St. Louis, 1970 Mosby.
Pp. 406. Illustrations 402 (\$29.59)

The book is divided into chapters on weight problems, obesity, cachexia, height problems, dwarfism, gigantism, sex problems, and precocious and retarded development. Each chapter is well planned so that the patient can be evaluated clinically, and studied logically. The cases are descriptive and informative, and the material is supported by useful references for further study. Good photographs illustrate the various endocrine types. The charts and tables present data for evaluation and investigation in such a manner to facilitate a correct diagnosis. The author includes some non-endocrine types for comparison and evaluation. The appendixes at the end of the book have a good selection of charts, curves, data, and tests which should be helpful. It is a worthwhile addition to the clinician's library.

NATALIJA MUSULIN, M.D.

Alzheimer's Disease and Related Conditions.

G. E. Wolstenholme and Maeve O'Connor, Baltimore, 1971, Williams and Wilkins. Pp. 305. (Price not stated)

In 1969, the Ciba Foundation held a symposium on Alzheimer's Disease and related disorders. The transactions are here released in a hard-cover volume. Most of the papers here reprinted concern the biochemical and histopathological aspects of this syndrome. Even the clinical findings are presented in terms of underlying pathology. There is no material on treatment. The book will interest neuropathologists, and, to a lesser degree, neurologists.

Henry A. Davidson, M.D.

Mental Health Team in the Schools.

Margaret M. Lawrence, M.D. New York, 1971, Behavioral Publications. Pp. 169. (\$6.95)

Unless one wants to read a report of the work performed a decade ago by the Rockland County (N.Y.) School Mental Health Unit, this book has little practical use for either the school physician or psychiatrist. It is poorly printed, and the type face would deter the reader even if the contents were intriguing. The style is stilted and almost camp. For example: "Alert, skilled, and personable Mrs. Corneilson remained in the Unit office."

The work of Doctor Lawrence was sincere and laborious, but the scope of this pilot program is limited. It is outdated in view of the strides in the past few years in the area of community mental health. It includes the work of a team of a psychiatrist, psychologist, and social worker who offered mental health consultation to the administration and staff of eight school districts consisting of about 30,000 children. If one eliminates the three case studies (or "plays" as they are termed), this leaves only about 100 pages of text. This book is of historical value for a researcher in the field.

SEYMOUR F. KUVIN, M.D.

Our Violent Society.

David Abrahamsen, M.D., New York, 1970, Funk and Wagnalls. Pp. 298 (\$7.95)

There is more violence in America than in other western nations. So says Dr. Abrahamsen, who offers here a psychiatric explanation for violent behavior. He sees personal violence as, essentially, a revolt against father or mother figures (authority or the mother country) rooted in childhood fantasies. He sees the American dream an embodiment of unconscious passions for power, strength, and control. "The American dream," he writes, "has traumatized us in that it has warped our outlook—become a powder keg of violence."

The author offers an interesting tabulation of "danger signs of potential violence" in the individual, and writes a prescription for effecting a change in our violence-oriented patterns of thinking, feeling, and acting.

ABRAHAM LEFF, M.D.

Hernia Repair Without Disability.

Irving L. Lichtenstein, St. Louis, 1970, Mosby. Pp. 210. Illustrated. (\$26.00)

This is an atlas intended to facilitate comprehension of hernial repair. The author also includes superfluous information: for example, chapters on "Incidence and Economic Significance of Hernia," or "The Dynamics of Wound Healing." Each chapter is followed by an aphorism (often trite) relating to the philosophy of surgery. A twenty-two page dissertation on "The Surgical Anatomy of the Inguinal Region" is selected from classical drawings from other references.

The author's contribution to herniorrhaphy, the Lichtenstein repair, is essentially the same as the classical Halsted repair. Dr. Lichtenstein has eliminated the use of the internal oblique muscle, which just about every surgeon since Halsted has done. He urges a plastic mesh screen to reinforce a new canal floor in the repair of direct and recurrent hernias. This is open to debate. His summation, "All hernias can be cured," is presumptuous.

Stanley S. Fieber, M.D.

The Low-Fat, Low-Cholesterol Diet.

Clara-Beth Young Bond, R.D., E. Virginia Dobbin, R.D., Helen F. Gofman, M.D., Helen C. Jones, and Leonore Lyon. Garden City, New York, 1971, Doubleday. Pp. 512. (\$7.95)

This book is a fine example of a volume which accomplishes what it purports to do—namely, to explain and construct low fat and low cholesterol diets. It explains the principles on which such diets are based. The aim is to substitute saturated fats by polyunsaturated fats and the elimination of high cholesterol food items. The saturated fats are mainly from tissues of animal origin, but may be found in some vegetable fats. They tend to raise blood lipids and cholesterol. Unfortunately, the vegetable fats usually used in so-called low fat prepared foods are coconut oils, which in themselves are highly saturated. The polyunsaturated fats occur mainly in liquid vegetable oils and, by replacing saturated fats, they tend to decrease blood lipids and cholesterol.

This book is particularly useful in translating these principles into actual menus, both practical and imaginative. There are meticulous instructions as to marketing, preparing, and even a list of mouth-watering sauces and desserts. Certainly, no one on such a diet need feel deprived. The book is well written and organized and anyone who must follow such a diet will find it exceedingly useful.

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NOVEMBER 1971
VOL. 68, NO. 11

NOVEMBER IS
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November 1971

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In edema and hypertension.

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have you
met them
socially?



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Hygroton[®] chlorthalidone USP *Indications:* Hypertension and many types of edema involving retention of salt and water. *Contraindications:* Hypersensitivity and most cases of severe renal or hepatic diseases. *Warnings:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant women and nursing mothers since the drug crosses the placental barrier and appears in cord blood and since thiazides appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte balance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. *Adverse Reactions:* Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization. *Average Dosage:* 50 or 100 mg. with breakfast daily or 100 mg. every other day. *How Supplied:* White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B)46-230-G For full details, please see the complete prescribing information.

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An epidemic
that's striking home...

gonorrhea

There were over 9,000 reported cases of
gonorrhea in the Garden State last year...
over 60 percent in Newark alone

In New Jersey...and everywhere else...
a new alternative

NEW Trobicin[®] SPECTINOMYCIN
DIHYDROCHLORIDE, PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

a chemically distinct antibiotic indicated specifically
for treatment of acute gonorrhea:

in the male—acute urethritis and proctitis

in the female—acute cervicitis and proctitis

when due to susceptible strains of *N. gonorrhoeae*

High cure rate: *96% of 571 males, 95% of 294 females

(Dosages, sites of infection, and criteria
for diagnosis and cure are defined on page 3 of advertisement)

Assurance of a single-dose, physician-controlled treatment schedule

**No allergic reactions occurred in patients with an alleged history
of penicillin sensitivity when treated with Trobicin,
although penicillin antibody studies were not performed**

Active against most strains of *Neisseria gonorrhoeae* *in vitro*
(M.I.C. 7.5-20 mcg/ml)

**A single two-gram injection produces peak serum concentrations
averaging about 100 mcg/ml in one hour**

(average serum concentrations of 15 mcg/ml present 8 hours after dosing)

NOTE: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

For full prescribing information, including contraindications, warnings and precautions, please see last page of this advertisement.

*Data compiled from reports of 14 investigators.

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Trobicin and the gonorrhea challenge

An accelerating epidemic— a decelerating susceptibility to penicillin

Gonorrhea is now the most prevalent reported communicable disease in the nation. The estimated number of new cases of gonorrhea in the United States exceeded two million for the first time in 1970. To compound the problems, strains of *N. gonorrhoeae* increasingly resistant to penicillin and other antibiotics are appearing throughout the country. Schedules of treatment which were effective only a few years ago now result in a significant percentage of treatment failure. *In vitro* studies have demonstrated that resistance of *N. gonorrhoeae* may also develop to Trobicin.

Thus, while aqueous Procaine Penicillin G remains the drug of choice for the majority of patients, the need for a non-penicillin, intramuscular antibiotic for acute gonorrhea in the male and female is abundantly clear. Such an antibiotic should be effective following a single intramuscular injection—and it should not demonstrate cross-resistance with penicillin

Trobicin—a new alternative specifically for the treatment of acute gonorrhea

Trobicin is indicated in the treatment of acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

High cure rates:

96% of 571 males, 95% of 294 females

Clinical Results with Single-Dose Treatment, Intramuscularly* (Data compiled from reports of 14 investigators**)

	Dosage	Number of Patients	Number Cured	Percent Cured
Adult Males: Gonorrheal urethritis	2 grams	475	457	96%
	4 grams	96	93	97%
Adult Females: Gonorrheal cervicitis	4 grams	294	280	95%

Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin medium in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluable and were not included in the table above.

No allergic reactions occurred in patients with an alleged history of penicillin hypersensitivity when treated with Trobicin, although penicillin antibody studies were not performed.

Chemically distinct

Trobicin is structurally not related to any other antibiotic commonly used to treat gonorrhea.

The assurance of a single-dose, physician-controlled treatment schedule

Intramuscular injections should be made deep into the upper outer quadrant of the gluteal muscle.

Adult male: Single 2 gram dose I.M. in acute gonorrheal urethritis. Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in gonorrheal proctitis and in patients being re-treated after failure of previous antibiotic therapy. In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams intramuscularly is preferred.

Adult female: Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in acute gonorrheal cervicitis and proctitis.

Safety for use in pregnancy has not been established, nor has safety for use in infants and children.

The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

*4-gram doses were injected in two gluteal sites.

**Medical Research Files, The Upjohn Company

a chemically distinct antibiotic indicated
specifically for treatment of
acute gonorrheal urethritis and proctitis in males
and cervicitis and proctitis in females
when due to susceptible strains of *N. gonorrhoeae*

new **Trobicin®**

STERILE SPECTINOMYCIN DIHYDROCHLORIDE
PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

Sterile Trobicin®

(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injection: 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.

Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic re-

sistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—single 4 gram dose (10 ml) intramuscularly.

How supplied: Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

For additional product information, see your Upjohn representative or consult the package insert.

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The Upjohn Company, Kalamazoo, MI 49001



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Bottle

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100210

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EDITORIALS

The Rising Tide of Self-Medication

As doctors, we have always frowned on self-medication by untutored laymen. The reasons are obvious. And since the development of television, the situation has become more distressing, with many TV commercials now showing the inside story of how Peregrin's Panacea Pills slide gently down the trachea into the spleen and, in technicolor, chase out the germs and the ulcers.

Yet, from time to time, medical people do say some kind words for self-medication. It has been suggested that there are fewer mishaps with harmless home medicines than with potent pharmaceuticals. It has been suggested that the rule of the market place applies and that the widespread popularity of non-prescription drugs must mean that they are doing something right. Most observers believe, however, that much of our country's orgy of self-medication is due to high pressure radio and television advertising. Some of it, let it be confessed, is due to the reluctance of some doctors to make calls on what sound like minor complaints. As a profession, we have to decide whether we should continue to oppose self-medication (and if so whether we should not, in support of our position, be more regularly and swiftly available) or whether we should encourage a wider use of the commercially advertised, over-the-counter, self-prescribed proprietaries. Or it may be that Gilbert Weil, the well-known New York attorney, was right when he said that people "have an instinct to medicate themselves" and that we would simply encourage "bootleg use of home remedies," if we continued to insist on the old-fashioned idea that only people who know something about pharmacology should decide which drugs ought to be poured into the human body.

More Than Two Million Dollars Paid

November is Life Month. This is the eleventh annual Life Month for The Medical Society of New Jersey Life Plan. More than 1,750 members currently participate in this Plan. During the past year, thirteen death claims were filed, bringing the total paid to \$2,115,000.

The Plan not only provides up to \$100,000 coverage for members, but a member's spouse, son or daughter, or employee can also participate in the program up to \$50,000 each. Each insured person, be he member, dependent, or employee, has an individual noncancelable life insurance policy at the extremely low group cost. It is not necessary for a member to be insured in order for his dependents or employees to participate in the program. The same liberal dividend structure applies to all policies issued under the Plan.

In addition to being a source of low-cost insurance for themselves, many members have found it valuable for their sons or daughters of college age because their children can retain the coverage throughout their lifetime as a permanent part of their insurance program. Once issued, all policies are renewable as term insurance to age 70 and guaranteed convertible at that time or earlier.

Professional Corporations have found the program ideal for a corporate benefit plan with employee coverage available and complete assignment of ownership and beneficiaries to suit every need.

During November, members under 65 are invited to apply for up to ten \$10,000 units of term life insurance including what they already carry. All policies have double indemnity benefit and waiver of premium as well as a guaranteed conversion privilege without extra cost. Complete information is being sent to members by our administrator, E. and W. Blanksteen Agency, Inc.

ORIGINAL ARTICLES

Here is a highly practical method for treating bladder decompensation.

Bladder Decompensation in Cancer, Cardiac Disease, and Stroke

Willard M. Drake, M.D./Camden

Many patients suffering from cancer, cardiac disease, and stroke are being denied the benefits to be obtained from urethral catheter drainage.¹ It is the purpose of this paper to review the etiology, diagnosis, management, and complications of bladder decompensation, and describe a method of determining the return of compensation.

Fear of urinary tract infections and Gram-negative septicemias complicating urethral catheterization has dissuaded some physicians from the use of the urethral catheter. Actually, the normal urinary tract (properly managed) will withstand catheterization and free itself of infection, even though infection may follow a period of catheter drainage instituted for bladder decompensation.²⁻⁹ Intelligent care depends on the ability of the physician to arrive at the diagnosis of bladder decompensation, his knowledge of catheter care, and his ability to determine the presence of the return of the bladder to a state of compensation.

Bladder decompensation results from lesions of the nervous system secondary to sensory loss, motor loss, or destruction of the reflex center; iatrogenically, from central nervous

system depressants, antihypertensives, relaxants, and local trauma; from inability to assume the natural position; and from primary urologic obstructive disease. Lesions of the nervous system may be primarily vascular, as in stroke; malignant, either primary or secondary; degenerative, as in diabetes, pernicious anemia, and multiple sclerosis; inflammatory, as in meningitis, poliomyelitis, and transverse myelitis; or secondary to trauma, involving the brain, cord, or peripheral nerves. The trauma may be primary or secondary to surgery.

Medications likely to cause decompensation from central nervous system action are anesthetics, narcotics, sedatives, hypnotics, antihypertensives, and tranquilizers. These usually allow the bladder to overdistend before the sensory stimuli get strong enough for the brain to recognize. Of the sedatives, barbiturates are least apt to cause bladder distention as they as a group tend to be parasympathomimetic. Muscle relaxants include the ganglionic blockers, bronchodilators, antihistaminics, sympathomimetics, and antihypertensive drugs.

Trauma secondary to childbirth, anterior colporrhaphy, urethral instrumentation, and abdominal perineal resection of the colon may

be sufficient to cause decompensation either by itself or in conjunction with the above-mentioned factors.

Primary urologic obstructive diseases capable of producing bladder decompensation include phimosis, meatal stenosis, urethral strictures and valves, prostatic hypertrophy, prostatic malignancy, prostatic abscess, and urethral stone. If present, these diseases must be treated before compensation can ensue. The urologist's work, in large part, involves bladder decompensation of varying degrees and he has the most extensive experience in catheter care and bladder decompensation, and its complications.

Initial symptoms of decompensation consist of frequency, urgency, and difficulty of urination. Later symptoms are pain, overflow-incontinence, and complete retention. Physical evidence of a lower abdominal mass, suprapubic dullness to percussion, with or without palpable mass, indicate a distended bladder. Further evidence is a decrease in P.S.P. and elevation of BUN or creatinine and x-ray evidence of retention on the postvoiding film of the intravenous urogram.

Treatment

Gently pass a latex or silastic Foley type retention catheter, using the sterile technic. Administration of Demerol® by hypodermic 20 to 30 minutes prior will facilitate this. Decompression of the bladder should be instituted in cases of chronic distention. A specimen should be sent for smear, culture, and sensitivities, and the catheter connected to a closed drainage system. Catheter hygiene in the male consists of the application of antibiotic salve to the urethral catheter junction once or twice a day after cleansing. In the female use a pitcher douche once or twice a day, using Zephirin® solution, or acetic acid (one eighth of 1 per cent), or similar agent.

Bladder irrigations may not be needed unless infection, debris, or obstruction indicate. Sterile-gloved technic should be used with solutions varying with the condition. Acetic acid

one eighth of 1 per cent is useful for Gram-negative and urea splitting infections. Commercially available buffered citric acid solutions may cut down encrustations. Commercially available antibiotic bladder irrigant is effective against most pathogens. Sterile saline and enzyme solutions are useful in breaking up mucus and blood clot. Silver nitrate solution is hemostytic.

Antispasmodics should be given initially and continued as needed; either ganglionic blockers such as atropine or antihistaminics or a narcotic. If these do not control spasms, an opium and belladonna suppository usually will. An antibiotic is ordered initially for five days usually a sulfa drug or a Nitrofurantoin®, to be changed if the clinical course or sensitivities suggest a different drug is needed.

The catheter or tubing should be secured to the clothing or bedding to prevent pulling of the retaining bag into the urethra, and in the male to keep the penis in the anatomic position to prevent pressure necrosis and abscess formation at the penoscrotal junction. The catheter should be changed at the earliest indication of poor drainage or sanding.

An alternative treatment, consisting of placement of a silicone rubber or polyethylene catheter by suprapubic puncture, for short term drainage until resumption of function, is being used successfully, especially in gynecologic procedures and in some pediatric applications.¹⁰⁻¹² Direction for use and proper care come with the commercially available kit. This avoids some of the tendency for infection and the urethral discomfort of the standard urethral catheter.

Infection will probably occur if the catheter is worn for more than four days. Infection will usually respond to the indicated antibiotic and be eradicated following removal of the catheter, when and if the bladder returns to compensation.

Spasm usually responds to the drugs listed. However, some patients (especially where nerve lesions of the upper cord or brain are

present) find that the catheter stimulates reflex activity which will tax the best efforts of the urologist. Narcotics by hypodermic needle or opium and belladonna suppository or local bladder instillations of Pontocaine® may succeed in interrupting this. Pyelonephritis, bacteremia, and septic shock result from failure to treat infection and spasm. Calculous disease of the bladder or kidneys is a late complication if the suggested treatment is poorly carried out. Periurethral abscess usually develops as a result of allowing the penis and catheter to fall between the thighs, producing pressure necrosis of the urethra at the penoscrotal junction. Treatment is best by prevention. Otherwise, suprapubic diversion and local drainage are necessary.

Compensation

1. An estimate of bladder compensation may be made at anytime but practically is deferred until the exciting cause has been treated and the patient has stabilized. The patient should be off heavy sedation and tranquilizers and be fairly mobile, that is, have bathroom privileges.

2. Physical examination should rule out an anatomic defect as obstructive prostatic disease which may require surgical correction.

3. An antibiotic should be begun the day before removal as determined by sensitivities and continued for three or more days as indicated. Antispasmodics should be discontinued.

4. By irrigation of the bladder with a bulb syringe, capacity, sensation of distention, and motor activity can be fairly accurately determined. A capacity of 350 to 450 cc., a sensation of desire to void at 250 cc., a fullness with more acute desire to void at 350 cc. or more are normal. Motor activity should cause urine to escape from catheter if held vertically under 30 centimeters of water pressure.

5. On the day of removal of the catheter the bladder should be filled with irrigating solu-

tion plus one syringe full of air, the catheter removed and patient allowed to void in a natural position. All the solution plus the air should come out. If no air comes out the catheter should be reinserted.

6. As an alternate to this, instill one ounce of 10 per cent Nitrofuracin® solution and remove the catheter; then have the patient record times and amounts of void. In either case the patient should be checked carefully for the next 48 hours to be sure voiding is of good quantity and there is no evidence of bladder distention by percussion or palpation.

7. Appropriate antibiotics as determined by sensitivity studies should be given as indicated, with follow-up for one to two months after catheter removal to be sure any infection is eradicated.

8. Patients with neurogenic or obstructive disease may require corrective surgery.

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with disks of oiled bamboo tissue paper. In the 18th Century in France upper-class women rediscovered the vaginal sponge, a device mentioned in sources as old as the Talmud.

It may seem now that such advances as oral contraception and the IUD have freed women from this often fruitless search and consequent suffering, but there are millions of women in the United States and elsewhere who have less knowledge of, and less recourse to, contraception than Egyptian women of the Twelfth Dynasty. Nothing is more urgent to all of us than to bring them help. We cannot long support the ecological pressures of an additional 70 million Earth inhabitants each year.

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain^{1,2} leading to this conclusion, and one⁴ in this country. The estimate of the relative risk of thromboembolism in the study of Vessey and Doll² was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because

these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function, increased sulfobromophthalein retention and other tests, coagulation tests, increase in prothrombin, Factors VII, VIII, IX and X, thyroid function, increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values, metyrapone test and pregnandiol determination.

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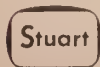
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Medical Leadership in a Changing World*

Sylvan E. Moolten, M.D./New Brunswick

The demands of society on the modern physician are not only to give comfort and consolation to the sick, not only to palliate suffering through the administration of tranquilizers, cortisone, digitalis, and other drugs, but to seek out and, if possible, to remove the causes of disease. Every thoughtful physician recognizes the importance of environmental factors. These include air pollution, unsanitary living conditions, and the contamination of food with pesticide residues. They also include the emotional tensions which exist in a mobile and competitive society in which overcrowding, racial hostilities, and the erosion of moral standards weigh heavily in the balance, especially with respect to cardiovascular disease, strokes, and psychosomatic disorders.

The causes of disease may indeed lie very deep within the individual's past. For example the clinical emergence of mesothelioma in the consciousness of physicians as a cancer to be considered in everyday diagnosis in contrast to its previous rarity is traceable to the increased use of asbestos in industry. What is important to recognize is that exposure to asbestos as a cause of mesothelioma may have occurred many years previously, since the average latent interval is 38 years.

Think of the many emotional disorders which rob our society of a wealth of skills and talents. The predisposition to a host of diseases (including even cancer) in patients who are unable to cope with life (the "giving-up"

syndrome) is commonly traced to early parental neglect resulting in a feeling of self-devaluation. This may be impossible to overcome in later life.

Compare the characteristics of disease in a modern world with what existed in a more primitive society. It will then become clear that the greatest threats to human life and health are those created by man himself.

The physician can do very little, if anything, about the causes of war or the threat of war. He can, however, exercise his influence politically and in other ways to combat air pollution and other pollutants in the environment. By his own example and precept he can help curtail the smoking habit ("walking pollution"). The physician in industry plays a prime role in reducing occupational disease and accidents. The physician can aid in the fight against alcoholism, which plays an important role in accidental injury and death, not only on the highways but in everyday life. Medicine has given its endorsement to the importance of proper nutrition. One area here in which the physician is concerned is in correcting dietary habits which predispose to coronary disease. The physician plays a powerful role in the emotional well-being of every patient. Even though he may not be aware of his influence, his words and deeds give a patient assurance and emotional support. The doctor must recognize the importance which society attaches to his moral leadership. "The concern for man and his

* Address presented at graduation exercises, Middlesex General Hospital House Staff, New Brunswick.

destiny must always be the chief interest of all technical efforts. Never forget it among your diagrams and equations." (Albert Einstein)

A "Letter to a Seventeen-Year-Old Son"[†] starts with: "Medicine is a pretty good profession, especially for one of your temperament which combines a better-than-average knack of getting along with people and a mechanical and scientific bent. But too many physicians, though expensively trained and full of medical information, are dull fellows and unenlightened citizens. This shouldn't discourage you from becoming a doctor; it should simply discourage you from being the kind of doctor who thinks human beings are just digestive machines with pocket-books, or that the circulation of blood is more important than the Constitution of the United States." Think, too, of Pellegrino's words, "The humanist physician should be essentially a philosopher of, and in, medicine. He must be responsive to the language of molecular biology and clinical medicine on the one hand, and that of contemporary philosophy on the other. He must enter a dialogue with philosophers, sociologists, and the literary humanists, but he must remain a physician, always conversant in the experiential dimensions of illness. The physician, like every other professional, lives at three levels of sophistication—as a professional, as a person, and then as an educated person. We cannot hope that every physician will live fully at each level. Some will only be competent and they are the technicians; others will be competent and compassionate and they will be the humane technicians; a few will be competent, compassionate, and also humanists in the sense we have defined it—they will be the compleat physicians. A concern for social change, for 'relevance' in education and behavior, promotion of the health and civil rights of the disenfranchised, changing the patterns of medical care delivery—all are equally 'relevant' for the humanist physician as defined here. Indeed, involvement in

change is a necessary expression of the physician's existence as a social being."²

Perhaps the physician is actually robbed of a certain stimulation to strive to achieve this goal. As suggested by Holman, "There is indeed an anti-leadership vaccine in medical education. The ingredients of the vaccine are satisfaction with self and with the existing state of affairs in science and medical practice, poor perception of trends in society, fear of erosion of status, mental fatigue, isolation from the student, and escape into specialization. John Gardner said, 'leaders worthy of the name . . . contribute to the continuing definition and articulation of the most cherished values of our society. They offer, in short, moral leadership. . . . When leaders lose their credibility or moral authority then the society begins to disintegrate. Leaders have a significant role in creating the state of mind that is the society. . . . They can conceive and articulate goals that lift people out of their petty preoccupations, carry them above conflicts that tear society apart and unite them in the pursuit of objectives worthy of their best efforts'."³

The training of a doctor must fit him for leadership in a changing world. But where is he to obtain such training? At the beginning of the century the education of physicians was guided by the precepts of our grandfathers. A radical change took place in medical education 30 or 40 years ago and now the changes are so rapid that one cannot rely on precepts of even 10 years ago. A large body of the material taught in medical schools becomes obsolete within five years.

The keynote in education of the physician today is that his training should be in the direction of education for uncertainty. The aim is to perpetuate an openmindedness to new ideas, a willingness to debate accepted principles and dogmas and to question all authority. The education of the physician after he leaves medical school should be in self-education, in learning how to learn. Continuing attendance at lectures and demonstra-

[†] Aring, Charles D. in June 1945 *Harper's Magazine*. Also see *The Pharos* for January 1969.

tions, while important for orientation and stimulation, cannot take the place of self-education.

In this respect, the community hospital occupies a key role in the orientation of the physician to his new role in society. The training of the intern or resident is based not so much on what he can absorb in the way of facts from senior physicians, but rather in being brought close to human problems in their stark reality. In the community hospital the medical graduate first obtains experience in the "doctor-patient relationship." He is taught to assume responsibility for the welfare of the patient under the guidance of experienced practitioners. Thus, he is instructed most of all in the fact that "the art of patient care is in caring for the patient" (Peabody). While he is given much responsibility for the treatment of the patient's physical ills he learns incidentally much about the nature of the patient as a person. The physician who embodies the qualities that set him apart from a technician is one who learns that it is not enough to treat the physical ailments and to achieve a normal temperature, normal white count, and normal x-ray, but also to win the patient's reassurance in his own well-being, expressed as "patient satisfaction," and to restore him to being a creative person secure in his own world of activity. In this sense the patient is actually a better source of instruction than physicians. The junior physician is guided by the examples of more experienced physicians and these examples may be useful (even though there may be bad examples as well as good examples). A physician teaches not so much by his familiarity with the medical literature as by the exercise of his priestly functions. Whether we like it or not, science has largely replaced religion as a support to people in our society.

The new religion of science, therefore, requires a new morality and a new priesthood. It requires that someone will speak to science as he has done in the past to God. The person who is supremely qualified for this formidable role is of course the physician. But this re-

quires that he be more than a technician. The physician of today and the physician of tomorrow must be a priest, not only to sick persons but also to sick society.

In assuming this new role of leadership a physician must establish and maintain his authority if he is to accomplish his purpose. He must learn how to maintain a perspective and, if necessary, stand apart from the turmoil of living in order to view it objectively and scientifically, yet at the same time maintaining his sense of compassion and commitment to the human situation.

One must, therefore, make a distinction between being "committed" and being "totally involved." In being committed the physician recognizes his obligations as a citizen and, therefore, imposes responsibilities upon himself to act in behalf of society. On the other hand, by becoming totally involved he may lose his position of authority and ability to command the political and social forces which make for a better condition so that in the end he may defeat his own purposes. To illustrate the point one might recall the conversation between the pig and the hen who were returning home from a barnyard pow-wow which had been called together by the other animals to decide on what to do for a poor family that lived down the hill. The family was destitute, had little or no food, and its members were constantly ailing. The hen suggested to the pig that the beginning should be in making sure that they had a proper diet, to be specific, a good breakfast every morning consisting of bacon and eggs. The pig, turning to the hen, commented, "I can see that you are truly committed. This I can understand and your idea has merit. However, if we are to follow your idea you would still be only committed but I would be totally involved."

A community hospital brings out the qualities in the young physician which make for leadership in his own social group and in society at large. It brings knowledge of other societies to the physicians who work together, including

those who are officially listed as "teachers." Actually the distinction between teacher and student is far from sharp. Older physicians who work in this community hospital owe a lasting debt to the younger physicians who come here, because they come here not only to learn but also to teach.

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A Federal Health Department

The AMA's often expressed desire to see the establishment of a separate Department of Health with cabinet status has again been brought to the public's attention with the announcement of Congressman Paul G. Rogers (D.-Fla.), chairman of the House's 'subcommittee on health, that he will shortly introduce such a measure.

The issue seems to turn on the intertwined questions of which committees in Congress have the job of enacting and overseeing a national health program and how the federal government will administer it. During the past decade health has mushroomed as an economic force in American life, and as a function of government. Neither Congress nor the executive branch has been able to keep pace organizationally with the changes.

Congressman Rogers' call for a separate health department may be seen as part of this behind-the-scenes jockeying by the Congress for more authority in health care matters. If a Department of Health were established, Rogers' subcommittee could claim authority over all of the activities of the new department and drive to establish a permanent full committee on health. However, Rogers' proposal runs head-on against current thinking in the administration, where policy has jelled in support of the current tri-function HEW apparatus. The trend of administration thought is that fewer departments make for more efficiency and less bureaucracy.

Medical Malpractice Commission

A Health, Education, and Welfare Commission has been formed to study malpractice problems. The commission will conduct public hearings on the fundamental factors behind the rising number of malpractice claims and their effects on the health care system, the legal system, the insurance industry, and the general public. Headed by Attorney Wendell Freeland of Pittsburgh, the newly created Commission on Medical Malpractice will represent health care providers and institutions, the legal profession, the insurance industry, and the general public. Acting as additional consultants to the commission will be advisory panels comprised of experts in the disciplines concerned.

The commission will compile data and relevant information in studies conducted by HEW primarily through contracts with non-government research organizations and universities. The commission will make a final report with recommendations to the HEW Secretary.

Eli P. Bernzweig, HEW's specialist in the medical malpractice area, has been named executive director of the commission staff. Loren F. Taylor, M.D., professor of Anesthesiology at the University of Kansas Medical Center, has been named deputy executive director. Charles Hoffman, M.D., president-elect of the American Medical Association and member of the AMA Board of Trustees, is one of the commission members.

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Facts about Loridine® I.M. cephaloridine

Facts about activity

Loridine is indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed below.* It is active against the following organisms in vitro:

Beta-hemolytic and other streptococci (many strains of

enterococci, e.g., *Streptococcus faecalis*, are relatively resistant)

Staphylococci, both coagulase-positive and coagulase-negative (some strains of staphylococci are resistant to cephaloridine)

Pneumococci

Gonococci

Hemophilus influenzae

Escherichia coli and other coliform bacteria

Klebsiella

Proteus mirabilis

Loridine also has demonstrated activity against *Treponema pallidum* in experimental syphilis studies in animals.

All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine. However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *H. influenzae*, *Pr. mirabilis*, *Esch. coli*, and *Klebsiella* are also susceptible in vitro.

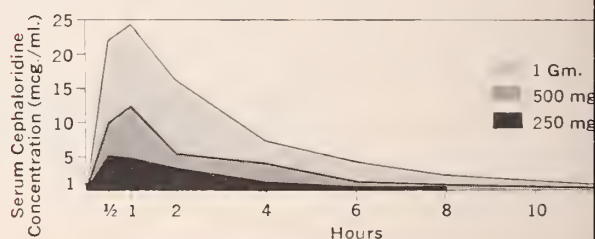
Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

* Loridine is indicated in the treatment of gonorrhea when penicillin is not considered the drug of choice.



Facts about dosage

In adults, most infections of moderate severity caused by susceptible organisms respond to Loridine in dosages ranging from 500 mg. to 1 Gm. every eight hours (1.5 to 3 Gm. daily). This use of lower dosages helps prevent drug accumulation. The more susceptible infections have been treated with 250 to 500 mg. every eight hours.



Mean Serum Cephaloridine Concentrations after I.M. Administration of Single Doses (250 mg. to 1 Gm.) to Normal Human Volunteers (Sixteen Subjects per Group). (Modified from Currie, J. P.: Cephaloridine: Pharmacology and Toxicology, Postgrad. M. J., 43 [Supplement 22, 1967].)

Peak serum levels have been noted with Loridine within one-half to one hour following I.M. injection. The mean peak serum levels obtained in normal subjects one hour after a 500-mg. I.M. dose ranged from 12 to 22 mcg. per ml. in separate studies. Administration every six to eight hours permits adequate concentrations to be maintained. In order to avoid excessive serum levels (which could possibly result in damage to the kidney tubules), recommended dosages should not be exceeded. In adult patients without azotemia who have mildly reduced renal function manifested by slight to moderate transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the maximum recommended dosage is 1 Gm. every twelve hours during the period of reduced function.

acts about administration

Following guidelines for therapy with Loridine are recommended.

Pre Administration of Loridine

Establish susceptibility of the pathogen.

Determine patient's renal status; Loridine is contraindicated in azotemia.

During Administration of Loridine

Maintain proper hydration.

Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.

Use cautiously with other potentially nephrotoxic drugs.

Because nephrotoxicity has been reported, limit dosage to 4 Gm. daily for adults (100 mg. per Kg.

for children—not to exceed adult dosage).

Usual adult dosage range: 1 to 3 Gm. daily.



5. In patients with impaired renal function *before* treatment, reduce daily dosage and keep them under close observation for changes in function. In nonazotemic patients with mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage (adults) is 1 Gm. every twelve hours during the period of reduced function.
6. In patients who develop impaired renal function or whose preexisting impairment becomes worse *during* treatment, discontinue therapy.

Since Loridine is relatively painless on I.M. injection, it is well accepted by patients.

There is clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins; therefore, Loridine should be used with great caution in patients with known penicillin allergy. Instances of patients who have had severe reactions to both drugs, including death from anaphylaxis, have been reported.

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Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine[®] (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest[®] tablets but not with Tes-Tape[®] (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred

in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important: Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin[®] (sodium cephaloridine, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 4 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 10 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine[®] (cephaloridine, Lilly), 500 mg., 5-ml. size rubber-stoppered; 1 Gm., 10-ml. size rubber-stoppered.

(08216)



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Offered here is a compact and practical monograph on anesthesia in plastic surgery in children.

Anesthetic Considerations in Pediatric Plastic Surgery*

Edward T. Lawless, M.D./Paterson

The two disciplines in surgery most aware of and sympathetic to anesthetic problems are plastic and thoracic surgery. Many technical problems related to these two specialties were handed to the anesthesiologist with the challenge for their solution. The pioneer work of Sir Harold Gillies and his co-workers¹ of the British Army Plastic Unit after World War I is now historic in the annals of surgery. No less historic to us are the contributions of Rowbotham and Magill, the anesthesiologists of that unit. They were faced with the necessity of providing safe, light anesthesia for plastic operations upon the face and upper respiratory passages which frequently lasted several hours during which they were unable to interfere with the patient without contaminating the surgical field. It was their use of the endotracheal tube in such plastic cases that gave the impetus to the development of endotracheal techniques.¹

The endotracheal tube is the foundation of our present-day concept of anesthesiology. Thus we are indebted for much of our development to certain problems of plastic surgery—problems mainly concerned with surgical lesions involving the head, neck, and airways.

In many areas we have failed to keep up with the demands put forth by plastic surgery.² Usually this happens in the non-specializing, general, or community hospital—the hospital where plastic surgery is but a small proportion of the surgical work-load, and especially in the hospital not devoted to the exclusive care of sick infants and children.

We shall here discuss some problems in plastic surgery in infants and children emphasizing the importance of communication and understanding between the plastic surgeon and the anesthesiologist.

Preoperative Preparation

Deliberate preoperative evaluation of each infant and each surgical procedure is imperative prior to anesthesia.³⁻⁴ Only by first-hand inspection can the anesthesiologist evaluate his problems. Since the size and vitality of infants and children vary greatly, as well as the magnitude of operations and the routines of individual surgeons, the technic of handling different children will vary widely and must be highly individualized.

The anesthesiologist, particularly one confined to a community hospital, would do well, in advance, to work out and even write down, step by step, his management of the case of a child presented to him for plastic surgery. These steps include the immediate preoperative preparation, premedication, the type and amount of fluid and blood replacement, the need for and location of a cut-down or percutaneous catheterization of a vein, the size of his endotracheal tube, the types of connectors, the position of the patient and the anesthetic equipment in relation to the surgeon and the table, the monitoring devices, the anesthetic agent and technic, the precautions to be taken for the fixation of the endotracheal tube, the prevention

* Read before the Section on Plastic and Reconstructive Surgery, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1971. This work is from the Department of Anesthesiology, St. Joseph's Hospital, Paterson, New Jersey.

of distortion at the site of the operation, the precautions on extubation, and special post-operative recovery management. Delineating this beforehand will set up a complete picture of the patient and the surgical condition and the anesthesiologist will be prepared to handle most situations as they arise. One cannot temporize with a child as one can with an adult. All preparations must be made well in advance, equipment must be laid out ready for use and the procedure not started until all this has been accomplished.

The surgeon can help by letting it be known that he *expects* such preparation from the anesthesiologist and by communicating with him, either orally or through the patient's chart or booking, concerning the magnitude of the lesion, any abnormal physical findings, and his own personal preferences. If the surgeon suspects complications he should certainly talk these over with the anesthesiologist by, at least, the day before operation.

Premedication

The correct preanesthetic sedation for the child coming to plastic surgery, especially on multiple occasions, is one in which the patient arrives at the operating room in a light sleep and remains that way during induction so no memory of the experience remains to produce emotional trauma.⁵

Much has been written concerning combinations of many various drugs for sedation.⁶⁻⁷⁻⁸ But traditional drugs, atropine or scopolamine; the barbiturates; and the narcotics, morphine and meperidine, seem to be most reliable.⁶ Rectal Pentothal,[®] in a dose not greater than 13 milligrams per pound of body weight, combined with atropine or scopolamine, has been used in our hospital for many years with satisfactory results in children from 24 months to about 10 years of age. We usually use a belladonna drug alone to age 12 months. From 12 to 24 months we add a short-acting barbiturate.

Monitoring

During anesthesia, temperature should be measured continually either by axillary,

nasal, rectal, or esophageal route. The blood pressure cuff should be used on all ages. A precordial stethoscope should be taped to the chest, if possible. An audible pulse meter is valuable and, in higher-risk patients, the electrocardiogram should be visible. A word of warning during monitoring is necessary. Monitoring probes may accidentally become points of high current density during the use of electro-coagulating or electro-cardiographic equipment and may cause burns or electric shock.

Thermal Regulation

Constant temperature monitoring during and after operative procedures is essential for the maintenance of body temperature. This is of paramount importance. Either hypothermia or hyperthermia can be fatal in children. Surgical anesthesia tends to abolish thermal regulatory power.⁹ Unintentional hypothermia is a complication of surgical anesthesia in infants and smaller children in a modern air-conditioned operating room. The body temperature drops to a greater degree during halothane anesthesia than with other inhalation anesthetics.¹⁰ Reductions in body temperature are further promoted by the use of the non-rebreathing system, by exposure of large surface areas and body cavities, by the administration of refrigerated blood, and the use of cold cleansing solutions and ether for skin preparation.⁹⁻¹¹

Hypothermia is a danger because it, *per se*, is a form of anesthesia and ordinary concentrations of anesthetics can be excessive with a drop in temperature. It alters the action of relaxants. It may cause hypoglycemia. It makes the determination of brachial blood pressure difficult. It causes hypoxia through respiratory and circulatory depression and bradycardia, and prolongs postoperative recovery, producing a sluggish patient with absent reflexes.¹¹

During the past several years fulminant hyperthermia (malignant hyperpyrexia), or rapidly developing hyperthermia under anesthesia, has been reported in both the United States and abroad.¹²⁻¹³⁻¹⁴ Seemingly healthy

young people are primarily affected. It carries an over-all mortality of 75 per cent.¹³ The incidence is small but increasingly being recognized and reported. Factors common to many patients have been the administration of succinylcholine and the maintenance of anesthesia with one of the potent agents, such as halothane or methoxyflurane. Many react abnormally to succinylcholine where rigidity replaces relaxation. Shortly after induction the patient's temperature rises to 106 or above. Successful management depends upon immediate recognition by continuous temperature monitoring during all anesthetics, and the knowledge of how to proceed once the emergency occurs.¹⁵ Since hyperthermia may occur shortly after induction, it seems reasonable for all children anesthetized with the potent agents to have an intravenous catheter inserted routinely for the immediate administration of chilled solutions which form a part of the emergency attempts to reduce the fever.

Fluid Replacement

In certain other instances, and with other technics of anesthetic management, the insertion of an intravenous catheter or cut-down is mandatory, as: (1) cases lasting longer than one hour, (2) possible significant blood loss, and (3) when pre-operative or operative dehydration or translocation of fluids is suspected or present.

If one checks the fluid intake and output during the day of surgery it will usually be found that it is the poorest of any day during the hospital stay. A few sensible guidelines can remedy what often seems to be a complicated problem in patient support.

- (1) If the child is losing extra-cellular fluid, the so-called "third space loss," give lactated Ringer's solution.
- (2) If not, as in "surface surgery," administer maintenance solutions, such as 5 per cent dextrose in 0.33 per cent sodium chloride.
- (3) Give 5 milliliters per kilogram hour of maintenance solutions, as a general rule.
- (4) Replace blood loss with lactated Ringer's solution up to 10 per cent of the child's blood volume. Over that, replace with blood, milliliter for milliliter.

- (5) Use glucose in water only to keep a vein open, or when one wishes to add sodium bicarbonate without saline.
- (6) Use maintenance electrolyte solution in the post-operative period. (2000 milliliters per square meter per 24 hours.)
- (7) Rules and tables for surface areas of children, maintenance fluids, and replacement of fluids, for cases of metabolic acidosis and potassium deficiency, and so on, should be immediately available for the anesthesiologist caring for children. Unless used daily, it is impossible to remember these figures with any accuracy.

Hemoglobin and Hematocrit

What are the minimal acceptable levels for hemoglobin and the hematocrit for children coming to operation? It seems preferable to maintain 10 Grams per 100 milliliters hemoglobin and 30 per cent hematocrit as the minimum standard.⁴ Justification for this lies in the fact that it allows a margin of safety in the event of unexpected acute hemorrhage. The anemic patient will become hypoxic faster than the nonanemic patient should anything interfere with his oxygen uptake.¹⁶ If just a minor degree of obstruction or under-ventilation occurs in an anemic patient, hypoxia will result.

Epinephrine

Injected epinephrine used during certain inhalation anesthetics is potentially dangerous and may produce fatal arrhythmias. Yet, plastic surgeons find its use advantageous to diminished bleeding at the site of surgery. To be used with relative safety, low plasma levels of epinephrine must be maintained during general anesthesia with halogenated hydrocarbons. Locally injected epinephrine during halothane anesthesia is permissible provided: (1) adequate ventilation is assured; (2) epinephrine in a solution of 1 to 100,000 to 1 to 200,000 is used; (3) the dose in adults does not exceed 10 milliliters of 1 to 100,000 epinephrine in any given ten minute period nor 30 milliliters per hour.¹⁷ The administration should be subcutaneous, avoiding an intramuscular or intravenous injection. The dose in children perhaps should not exceed one half of the adult dose, or 5 milliliters of 1 to 200,000 solution of epinephrine in ten minutes.

Endotracheal Intubation

Plastic surgery about the head and airways of any consequence requires endotracheal anesthesia for proper airway control. It is also needed to separate the anesthesiologist and his equipment from the operative field. Exceptions are those operations which can be safely performed with local anesthesia and sedation,² or with the use of ketamine, the recently introduced dissociative agent. Specific technics depend on the experience of the anesthesiologist and the preference of the surgeon. This is a prime situation where communication is most important between the two specialties. The surgeon can become frustrated and annoyed working with many different anesthesiologists of varying degrees of pediatric experience and skill, and using different anesthetic managements for the same procedure. In like manner, the anesthesiologists will be confronted with different plastic surgeons each demanding his own approach for the one operation. Discussion and understanding between the two before operation can do much to work out a reciprocally satisfactory atmosphere.

Several rules govern all endotracheal technics in children. Infections and trauma are the greatest causes of laryngeal edema and tracheitis following intubation. Since this is so, remember:

- (1) Do not operate on a child with a respiratory infection or a recent respiratory infection.
- (2) A sterile disposable plastic tube is probably the least traumatic. (Be suspicious of ethylene oxide sterilization.)
- (3) Use the largest possible tube that can be inserted without glottic or cricoid resistance.
- (4) Muscular relaxation *via* depth of anesthesia or relaxant drugs should be obtained before intubation.
- (5) Before anesthesia, tubes should be selected of proper diameter and length.
- (6) Proper adapters should be positioned and fixed in tubes before intubation.
- (7) Tubes should be fixed to prevent dislodgement or descent into a bronchus.
- (8) Tubes should not interfere with the operative procedure or distort the surgical field.

- (9) Movement of the head or bucking on the tubes should be minimal to prevent a sawing-motion of the tube in the larynx.
- (10) When working on head and mouth, the surgeon should be constantly aware of the endotracheal tube and should not disturb it without notifying the anesthesiologist.
- (11) Weak and newborn infants less than ten days old should be intubated awake. Pre-oxygenation is a prerequisite to awake intubation.
- (12) Provision should be made for heat loss and proper humidification for all procedures lasting over one hour.

Post-intubation edema of the larynx can be extremely dangerous. At the least suspicion of stridor or croup in the recovery period institute the immediate therapy suggested by Jordon, Graves, and Elwyn.¹⁸ This consists of positive pressure breathing with racemic epinephrine. The routine treatment of persistent laryngeal edema is steroid therapy (Decadron® 4 to 8 milligrams intramuscularly), a cold humidified atmosphere, oxygen, antibiotics where indicated, and bendryl® 0.25 mg/lb for restlessness.

Observation of the child in the immediate postoperative period is important. The anesthesiologist and the plastic surgeon should not leave their problems at the recovery room door. Respiratory and circulatory difficulties, proper electrolyte and fluid maintenance, temperature changes, and post-operative bleeding make this period most hazardous.

Succinylcholine Induced Hyperkalemia

Succinylcholine has been associated with the occurrence of fulminating hyperthermia. This drug may produce lethal hyperkalemia during anesthesia in severely burned or traumatized patients or in patients with neuromuscular disease.¹⁹ In these patients relaxation during anesthesia should be obtained with tubocurarine or gallamine.

Newer Agents

Fairly radical changes are taking place in the basic concepts of general anesthesia. New technics and drugs are replacing old ones which aim at the retention of protective re-

flexes and the support of vital functions of respiration and circulation. These drugs act differently from most general anesthetic agents. They affect the central nervous system in a specific way, usually by severing the patients control with his surroundings and by providing a degree of general analgesia. Neurolept analgesia, as represented by a mixture of fentanyl and droperidol (Innovar®); dissociative anesthesia, as represented by ketamine and diazepam and similar compounds, are examples in point.

We have found ketamine particularly of advantage in children. It can be used by the intramuscular or intravenous route for lesions that are relatively superficial, for dressing changes, skin grafts, debridements and for cases not of great magnitude. It reduces the use of an endotracheal tube in many cases. It tends to cause increased secretions and should not be used alone where the danger of respiratory obstruction exists, as in operations in the mouth and airways.

Innovar® has yet to find its place in anesthesia for infants and children. It must be used as any narcotic and tranquilizer is used.

Summary

The demands put forth by plastic surgery in children are a challenge for meticulous and constantly changing anesthetic management. Recognition by the surgeon and

anesthesiologist of proper evaluation of the child, with knowledgeable preparation, drug use, monitoring and support during and after surgery is necessary to meet these demands. Several of the problems have been discussed. Key to success lies in the liaison between surgeon and anesthesiologist.

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New Drug Abuse Pamphlet

The American National Red Cross announces a new drug abuse pamphlet worked out by the National Academy of Sciences—National Research Council. The 14-page pamphlet, "Drugs and Their Abuse," describes the effects of drugs, their abuse by some persons, the symptoms they create, and the first aid care that should be given to anyone who has taken or who is suspected of

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Dr. David E. Smith is Director of the Haight-Ashbury Medical Clinic in San Francisco, California, and Assistant Clinical Professor of Toxicology, University of California Medical Center at San Francisco.

Dr. William Abruzzi was Medical Director of both the Woodstock and Powder Ridge Rock Festivals and is currently the College Physician, State University of New York at New Paltz, New York.

Dr. Edward C. Senay is the Director of Clinical Research for the Illinois Drug Abuse Program and Associate Professor of Psychiatry at the University of Chicago School of Medicine, Chicago, Illinois.

Their taped discussions are on automatic telephone equipment for utilization at all times. The opinions given regarding treatment modalities are those of the physician speaking.

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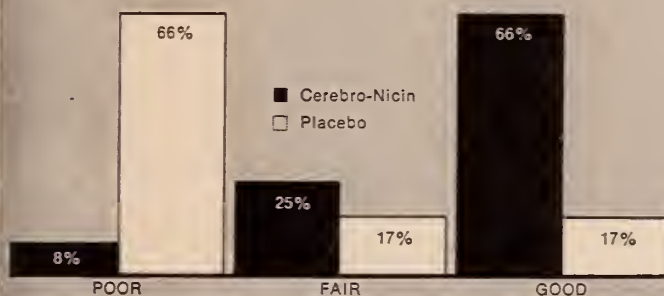
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl. of the Amer. Ger. Soc., June, 1964

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Fertility and Sterility, January 1970
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Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B₁₂.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

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Specific therapy for night leg cramps

Recent adverse publicity should not deter physicians from using oral antidiabetic agents.

University Group Diabetic Program and the Practicing Physician

Otto Brandman, M.D./Newark*

When insulin was introduced, it was properly hailed as a milestone in the management of diabetes. Indeed, diabetic acidosis which was the common cause of death before the discovery of insulin was reduced to a minimum. The patient who dies today in a diabetic coma is a rarity—mostly due to prolonged neglect on the part of the patient, or as a result of an overwhelming acute infection.

In the next 30 years, treatment of diabetes consisted of adherence to a regimen of a specific diet and dose of insulin which would keep the blood sugar level as close to normal as it is possible without causing hypoglycemic reactions. The long acting insulins (PZI, NPH, Lente, and Globin) which appeared in the late forties did not substantially change the mode of therapy. It allowed, in most cases, the reduction of the number of injections to one daily, frequently by using a mixture of the long acting insulins with the regular insulin, according to the patient's needs. With few exceptions treatment of diabetes in the United States followed the regimen of the Joslin Clinic. The excretion in the urine of 5 to 7 per cent of glucose of the consumed Grams of carbohydrates were considered safe but with the emphasis placed on the near normal blood sugar in the morning, which would allow the patient to start the day like "a normal individual."

We all assured our patients that following

the diabetic regimen (insulin and diet) would give them a normal span of life and prevent the much feared complications, which started to face the patient as soon as a juvenile diabetic approached middle life. Many of us had misgivings about this approach and some expressed their reservations openly at meetings and in publications.

The middle fifties brought us a new weapon in the fight against diabetes, the sulfanylureas and phenformin—recommended for the maturity onset diabetics. This permitted the physician to discontinue insulin in many patients, who, up to now, had had to rely on insulin and could not be controlled by diet alone. Many of us frequently used these agents when the patient relaxed his diet and our consciences felt better when the blood sugar was lower and the urine free of glucose.

In June 1970, at the American Diabetes Association meeting in St. Louis, the UGDP† presented a paper by Prout¹ of Johns Hopkins. This was the result of a ten-year study in twelve university centers about the value of hypoglycemic agents in the treatment of diabetes. The study included 823 patients who were divided into four groups: (1) placebo and diet; (2) tolbutamide 1.5 Gram daily

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and diet; (3) fixed dose of insulin and diet; (4) diet and insulin according to the needs to keep the patient well controlled.

Results of this study were discouraging.[†] It was a jolt and produced a storm in the ranks of the leading clinicians engaged in treatment of diabetes. The fact that tolbutamide proved not only *not* helpful in the management of diabetes but actually was harmful (because it increased the death rate due to coronary heart disease) provoked, to put it mildly, a heated discussion which certainly isn't over yet.

A comparison of the placebo and diet group and diet plus variable insulin group does not reveal any difference in the incidence of non-fatal cardiovascular events—a discouraging finding, since as Prout¹ remarked, “we have not altered the course of events much with insulin treatment.”

However, in the over-all evaluation, the cardiovascular death rate was higher in the tolbutamide group in four out of twelve centers engaged in this study.

It is impossible in this short review to go into details of particular arrangements of this study and validity of drawn conclusions. The most obvious inconsistencies in the study are:

(1) The fixed dose of tolbutamide or insulin is not a reliable mode of therapy.

(2) In four centers, the cardiovascular death rates in the tolbutamide group were high (31.8 per cent, 25.0 per cent, 23.5 per cent and 18.2 per cent). In four others, the tolbutamide death rate was zero, and in one of these groups where the tolbutamide death rate was zero, the insulin variable death rate was 9 per cent.

(3) Only in 75 per cent of the investigated patients, complete adherence to diet and medication was achieved.

(4) “Eighty-three patients during the study had their medication reduced, or discontinued on their own. As a result the investigators were confronted with the problem of deciding whether fatalities should be associated with treatment that had been taken unfaithfully, altered in others, or maintained in an uncertain manner by others.”²

(5) A very important factor in developing arterio-

sclerotic heart disease and infarctions—smoking—was not taken into consideration in the over-all evaluation.

(6) Of the patients treated, 23.4 per cent did not have diabetes according to United States Public Health criteria and 53 per cent had a fasting blood sugar of 130. Most clinicians do not prescribe hypoglycemic agents unless the fasting blood sugar is over 130.

(7) One-third of the UGDP patients were more than 50 per cent overweight and should have been treated by low caloric diet and not with tolbutamide or insulin.

In the discussion that followed, Keen³ from London, and Paasikivi⁴ from Sweden quoted figures from their studies which essentially proved the opposite from the findings of the UGDP. They found that the cardiovascular death rate of diabetics treated with sulfanylureas was lower.

On November 20, 1970 a number of outstanding clinicians and researchers in the field of diabetes met in Boston to discuss their “mounting concern for more than one million diabetics who have become increasingly restive because of newspaper stories alleging adverse effects from long-term use of oral anti-diabetes agents.”⁵ They deplored the premature acceptance of the UGDP study by the Food and Drug Administration, by the Council of the American Medical Association, and by a Committee of the American Diabetes Association. No similar observation has been reported from any other source here or abroad after 15 years of use of anti-diabetic agents. They submitted a recommendation to the Food and Drug Administration to modify the FDA Drug Information letter and requested an independent evaluation of the statistical and clinical findings of the UGDP study. Among the signers of this letter are such outstanding physicians as Holbrook Seltzer from Southwestern Medical School, Peter Forsham, University of California Medical Center, Rafael A. Camerini-Davalos, New York Medical College, Robert F. Bradley and Alexander Marble from the Joslin Clinic, John M. Moss from Georgetown University, and many others whose names I cannot list in this short review.

At a recent meeting of the American Geri-

[†]University Group Diabetic Program.

atric Society, Conlon⁶ presented figures from an eleven year study of 673 diabetics which suggested that oral hypoglycemic agents are quite safe. Marble,⁷ pointed out that a retrospective study at the Joslin Clinic of 901 male patients revealed a statistically significant difference in deaths from coronary heart disease among 220 patients treated with sulfanyl-ureas, (58 per cent) as compared with 498 in patients on insulin (40 per cent). But among 902 female deaths attributed to coronary artery disease, the rate was the same for those treated with sulfanyl-ureas (54 per cent of 190 patients) as with those on insulin (55 per cent of 594 patients). Taking the total of 1803 patients of both sexes, 56 per cent of those treated with sulfanyl-ureas and 52 per cent of those treated with insulin died of coronary heart disease, thus showing no statistically significant difference.

The Canadian Diabetic Association issued a statement (published in the May 1971 Bulletin of the Food and Drug Directorate) disagreeing with the findings of the UGDP study: "There is no acceptable evidence at present that tolbutamide is harmful, and there is, therefore, insufficient reason to issue warnings or restrictions on its use in this country. The Association suggests that tolbutamide and other oral hypoglycemic agents should continue to be used at the discretion of the physician in appropriate cases of diabetes which cannot be controlled on diet alone. The Association feels that the warning issued in the United States and the publicity surrounding it have been precipitous, and possibly detrimental to the welfare of diabetic patients."

A recent discussion of the UGDP at the American Diabetes Association meeting in June 1971 did not add anything significantly new to the controversy. Prout¹ presented the same findings again as in 1970 at the St. Louis American Diabetes Association meet-

ing and Bradley, from the Joslin Clinic, quoted figures from the Boston group which were comparable to Marble's⁷ findings. The three non-partisan discussor experts in other fields, Brounwald, Lasagna, and Stamler criticized the UGDP study on the basis that the members of the team overlooked the complexities of the cardiovascular disease and the fact that the etiology of arteriosclerosis is still an unknown factor. The group study ignored also the cumulative risk factors in the tolbutamide treated patients.

In conclusion, in the opinion of most investigators and clinicians, the UGDP study did not present convincing evidence that the oral hypoglycemic agents are contributing to the increased cardiovascular death rate. The study group and their critics seem to agree on one issue, namely that the present methods of treatment of diabetes are not contributing to the prolongation of the life of the diabetic. However it is an uncontestable fact that the neglectful diabetics provide the highest ratio of hospital admissions.⁹ Closer attention to better control, insulin in the juvenile form, and oral agents in the maturity-onset diabetics seem to help patients to lead a more useful life and may delay many ultimately unavoidable complications.

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Patients fell asleep quickly

Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.^{1,2}

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electroencephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

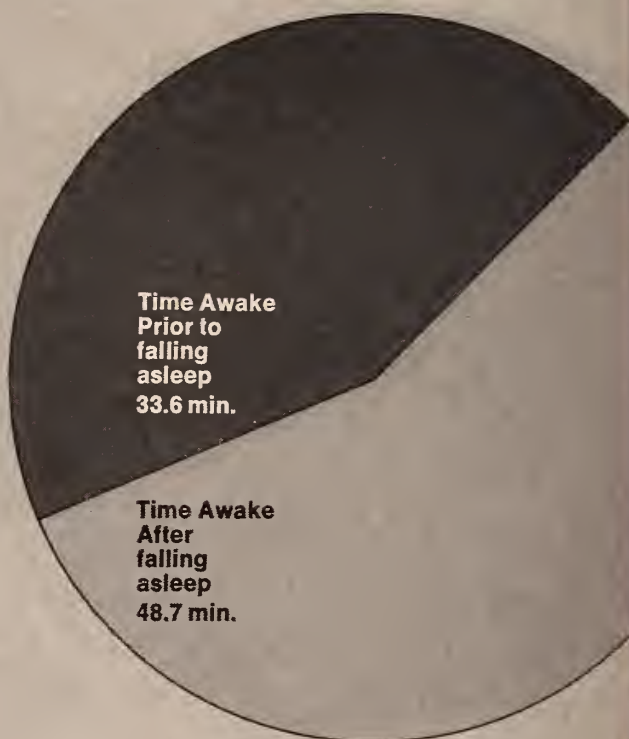
Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

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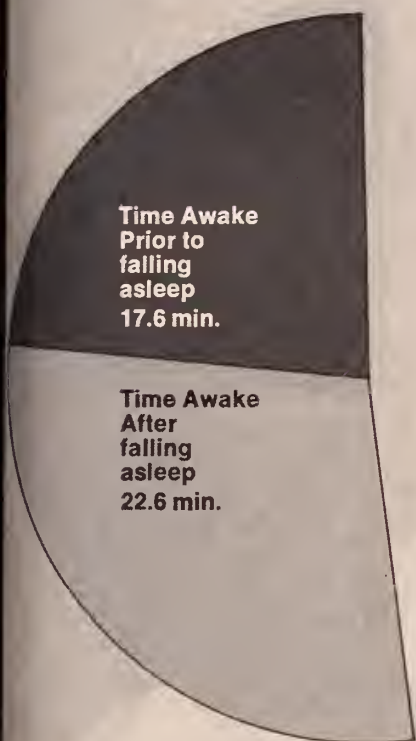
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

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and slept through the night

On
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Large sleep laboratory measurements in cited studies

Parameter	Before Dalmane	On Dalmane
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Time after onset of sleep	48.7 min.	22.6 min.
Number of wakeful periods after onset of sleep	12.2	8.4
Total sleep time	420.0 min.	447.5 min.
Percentage of sleep	88.6	94.5

clinical effectiveness as
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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

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When a person is drunk enough to require medical attention, the physician had better know not only what to do but what not to do. Dr. Fagan here presents some practical suggestions.

Management of Acute Alcoholism

Paul Fagan, M.D./Bloomfield

Alcoholism is a chronic disease and to be effectively treated must be so recognized. The acute episode is only the smallest manifestation but does present a frequent problem for the emergency room physician. The following comments are suggestions for treating the acute episode.

Acute alcohol intoxication is an acute psychotic state. Delusions or paranoid ideas suggestive of a chronic psychotic reaction may be evidenced. Evaluation and diagnosis must be deferred until after the toxic effects of the alcohol have been eliminated.

1. Be alert for: (a) Skull fractures, (b) Subarachnoid hemorrhage, (c) Urinary tract infections, (d) Atypical pneumonia and tuberculosis, (e) Aspiration pneumonia, (f) Pancreatitis, (g) Duodenal ulcer, and (h) Cirrhosis.

2. Do not use Paraldehyde:

- a. A marked cross-tolerance exists.
- b. Paraldehyde addiction occurs readily and is more discouraging to treat than alcoholism.
- c. It is a toxic substance, a polymer of acetaldehyde, which is the first breakdown product in the metabolism of alcohol.
- d. Sudden death has been reported following use of paraldehyde.
- e. Most paraldehyde is excreted through the liver.

3. Do not use barbiturates:

- a. A high proportion of alcoholics are already addicted to barbiturates.
- b. Large doses have surprisingly little sedative effects

on these patients. Frequently paradoxical excitement is produced.

- c. Barbiturates (except phenobarbital) are excreted mainly by the liver which in the alcoholic may be acutely or chronically damaged. Phenobarbital is too slow acting to be of real value.

4. Do use Librium®. Physical restraint can usually be eliminated by using this drug 50 to 100 mgm by mouth or intramuscularly every three hours. Dosage should be titrated since Librium® can be cumulative.

If the patient's general condition is satisfactory but he has been vomiting or is clearly dehydrated, give intravenous fluids. Two thousand cubic centimeters, half of which should be 10 per cent glucose in distilled water and the other half 5 per cent glucose in normal saline. Add 100 milligrams of thiamin and 5 cubic centimeters of B-complex concentrate to each bottle. This should be given rapidly, as fast as it will run through a number 19 needle if there is no question concerning cardiac reserve.

A tachycardia in the neighborhood of 120 per minute is not unusual as withdrawal symptoms appear and is not a contraindication to intravenous fluid therapy.

Always draw blood for blood sugar determination before starting intravenous glucose to rule out hypoglycemia and hyperglycemia, both of which can occur in the acute alcoholic.

Never give intravenous glucose without adding 100 milligrams of thiamin to each 1,000

cubic centimeters. Without thiamin, acute precipitation of Wernicke's Syndrome has been observed. Oral fluids and nutrition are preferable if the patient is able to take them.

The patient has eaten little or nothing for days or weeks and it is reasonable to suppose the body's glycogen reserve is low, though the blood sugar will ordinarily be normal. There is biochemical evidence that the electrolytes are not significantly altered, except for a slight decrease in chloride.

5. Tranquilizers in the acute agitated alcoholic, like reserpine or meprobamate are not effective *at this time*, although they may have a place in treating the alcoholic experiencing withdrawal symptoms.

6. Complications:

a. *Convulsions*: The seizure is indistinguishable from any grand mal epileptic fit. It usually occurs three or four days after the last drink. It is not a cause for alarm. No specific treatment is indicated, nor is the fit likely to recur immediately. An electroencephalogram will show nonspecific changes that eventually revert to normal. The spinal fluid is normal. A person who has had an alcoholic convulsion is likely to have another if he embarks on another binge.

b. *Acute Hallucinosi*s: This is the most common form of acute brain syndrome in alcoholics. If mild, it can be handled on an outpatient basis though hospitalization is always desirable. Hallucinations may be auditory or visual or both. They may be frightening or the patient may find them merely interesting. Usually, some degree of apprehension is noted because the hallucinations are likely to be bizarre. Pink elephants are rarely seen but small insects are common. Auditory phenom-

ena frequently take the form of voices calling the person by name (usually without paranoid overlay). He may hear radio programs not perceptible to others. The patient may tell you, for instance, that he heard a radio at home even though he had pulled the plug out. This indicates that he is in some degree of contact, which is generally true. He will ordinarily be fairly cooperative and may be amenable to reassurance that his hallucinations are imaginary. He does not appear physically very sick. Distinguish this syndrome from delirium tremens: a catch-all diagnosis freely applied to any form of acute brain syndrome or even to a person showing some degree of somatic tremor. Actually, it is a specific entity which constitutes a major medical emergency and requires immediate and energetic treatment in a hospital. The patient is obviously and seriously ill. There is fever, usually 101 or more. He is delirious and entirely out of contact. The stream of talk is continuous and incoherent. Psychomotor agitation is present. Patients should be sedated with a sufficient amount of Librium® and should then be vigorously hydrated. Death is most often from hyperthermia or heart failure. With careful supervision and good nursing care, uncomplicated delirium tremens should rarely result in death. Admit this patient to the hospital and do not attempt to treat him as an outpatient.

7. Every acute alcoholic should have follow-up, long-term care if his chronic alcoholism is to be controlled and repeated acute episodes are to be avoided.

Immediately after the patient has sobered up, and while he is still hospitalized, he is in the most receptive mood for the suggestion of need for him to seek outpatient, long-term help. Referral to the Alcoholism Treatment Center is indicated at this point.

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experience
compounds
the pain**



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Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. *Contraindications:* Hypersensitivity to any of the components. *Precautions:* As with all phenacetin-containing products, excessive or prolonged use should be avoided. *Side effects:* Side effects are uncommon, although nausea, constipation and drowsiness may occur. *Dosage:* Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

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CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

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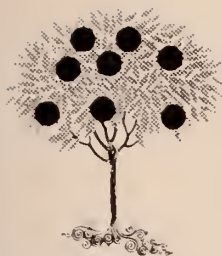
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Whether he knows it or not, every physician becomes involved in a "transference" in relations with his patients and may be a factor in "regressing" them.

The Difficult Patient in Medical Practice*

**Lawrence Deutsch, M.D./Englewood
Discussors: Milton Shoshkes, M.D./
Millburn and Paul F. Syracuse, M.D./
Irvington**

There is need for psychiatrists and psychoanalysts to share certain aspects of their expertise with other branches of medicine. We live in an era of "Sensitivity Therapies," "Encounter Groups" and cults, whose proponents have better public relations men and better press liaison than we do. Hence the average busy surgeon, internist, or pediatrician has little opportunity to revitalize his psychiatric knowledge.

Physicians find themselves in the position of being among the most revered and the most reviled of professionals. Admiration tends to be more overt, but hostility tends to be more covertly demonstrated. Patients will complain to friends about a doctor's ineptness, the time spent waiting, the unnecessary workup or the exorbitant fee. Patients often show unconscious hostility by procrastinating in paying bills, by arriving late, or by cancelling appointments. Other patients show their ambivalence condemning all doctors but for one or two who are then labelled "honest" or "old-fashioned type doctor." Most physicians, in truth, are sincere and dedicated, and are the recipients of many patients' marked ambivalence. We would profit from examining some of the causes of such ambivalence, hopefully to learn to handle common office problems more effectively.

Sick people come to us for a "cure." When we see them, we ask them to bare themselves

to us, psychologically and physically. Thus, we are seen as omnipotent and parental. When a young child is hurt or ill, the parent is clearly seen as omnipotent, the one who will cure or arrange a cure. Young children are not only physically handled and examined by their parents but are expected to reveal all the details of their illnesses, which is similar to our history taking. A transference of feeling from parent to doctor takes place even before the patient knows very much about his physician. This transference is accompanied by some level of regression and infantilization. Every physician should be aware of the developing transference. The regression should be qualitatively and quantitatively appropriate. We can understand this process by recalling our own experiences as patients.

The physician's attitudes and behavior may color, strengthen or potentiate aspects of the transference. I shall focus my attention on two general issues, (a) how to understand the nature of the transference at any given time, and (b) how to handle certain basic types of interplay in order to have a transference that works to a patient's best advantage.

Psychiatrists, in dealing with transference reactions, have the advantage of knowing significant past family and developmental his-

*Read before the Section on Psychiatry and Neurology, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 16, 1971. Dr. Deutsch is Clinical Associate Professor of Psychiatry, Downstate Medical Center, New York; Dr. Shoshkes is an internist on the staff of the Overlook Hospital in Summit, and Dr. Syracuse is a psychiatrist on the staff of Clara Maass Hospital in Belleville.

tory and thus of being able to assess and to anticipate the transference. This transference is a repetition of the patient's earlier attitudes toward his parents. All physicians should be aware of the ubiquity of transferences, should avoid overly intense transferences and should discourage excessive infantilization of patients.

Some patients feel they have fallen in love with their physicians. This applies to patients of both sexes and applies to both overt and covert seductive behavior. Patients are constantly fencing with their doctors in an attempt to determine and control the personal level of the doctor-patient relationship. This is particularly the case with those patients who tend to be more infantile and who, therefore, feel that good medical care can be forthcoming only when a doctor has a special personal and even physical interest in them. There is a wide spectrum of ways in which persons make passes at their physicians. For example, on one end of the spectrum there are those who are overtly seductive and invite sexual episodes. At the other end there are those who seek to find common interests with their doctors in order to assure interest in themselves. Some patients regress further on an experimental basis to determine if the regression itself will interest the doctor. An illustration of this last situation might be a patient calling his physician, internist, psychiatrist, and so on, to ask advice on the treatment of some minor illness that certainly did not warrant the physician's attention. Sometimes such patients will demonstrate the regression involved by introducing themselves by their first names, assuming that they are children, known by their first names and known to their doctors. Thus, a new patient, let us say Miss Smith, may well call her physician and say: "Dr. Jones, this is Jane, and I want to ask you about a problem that I have." There are countless varieties of such seduction. There are some patients who use shocking sexual language, others who insist on relating sexual exploits and still others who permeate each visit with "dirty" jokes. Many physicians have developed technics for handling the seductiveness of their patients.

However, some physicians are so flattered by this (and other physicians so flustered by patients' seductive behavior) that they do not handle it appropriately. For example, when a patient calls and says, "This is Jane," Dr. Jones might say, "Jane who?" Let us say the patient replies, "Why, Jane Smith, I saw you last week." At this point if the doctor replies, "Why yes, Jane, what can I do for you?", he will set a different tone than if he says, "Why yes, Miss Smith, what can I do for you?" Someone might object at this point saying that the patient is only trying to be friendly, not necessarily seductive. This is not really the issue. It may be quite appropriate under certain circumstances to use a patient's first name. The issue is to understand behavior in terms of transference, regression, and infantilization. We do not wish to infantilize our patients unnecessarily. The medical situation carries with it an adequate amount of infantilization and regression even when patients are encouraged by the doctor-patient relationship to a more mature state. The physician who is flattered by the patient's interest in him, need ask himself: "Is this patient interested in me personally, or is this patient seeking good medical care by a technic that she employed all her life with her parents?" In most cases it would be the latter, that is, purely a transference relationship. This orientation allows us to deal with the patients who are overtly seductive. One can sit down with a patient and explain in appropriate language some of the things that I have presented here. One must learn to explain to a patient in a discreet manner that his or her feelings are understood to be sincere and are very flattering, but that in the physician's opinion they represent a transference of feeling in an attempt to develop a feeling of security. Each physician must use his own language and must be kind and sincere. One way of discouraging regression and infantilization in the medical office, is the use of gowns. Other ways are: examining part of the patient at a time while covering other parts, presence of office nurse, and arranging to have the patient dress, leave the examining room, and come into the consultation room before discussing the findings. In a few

special situations. encouraging regression may be salutary. However, a physician must be certain that it is for the patient's benefit and neither for the physician's pleasure, nor for the sake of expediency.

Physicians are constantly faced with the problem of reassuring anxious patients. Let me illustrate some of the inherent difficulties and complexities involved in this process. I was teaching a group of medical residents and presented them with a hypothetical situation. I said, "Let us suppose that a 28 year-old woman came to your office with a small lump in her breast, one that she had recently noticed while showering. You confirm the presence of this lump and indicate that surgical intervention is mandatory. Then let us assume that the patient begins to sob. What do you do to reassure her?" One resident said that he would assure her that she most likely did not have breast cancer since in her age group, and with the appearance of the lesion, it was most probably benign. Another resident said that one could never be certain of this. Anyway, the fact that every patient has to sign for a possible radical mastectomy contradicts this. He felt that his approach would be to point out that even if it were malignant the patient had discovered it early and the prognosis for cure and survival was good. The third resident disagreed. He felt that patients were more afraid of being maimed. It was his experience that women feared the loss of sexual attractiveness and that some feared the inability to have children after such surgery. He felt that these were the factors with which to deal. Yet another resident suggested that the patient might need reassurance about the operative procedure, the anesthesia, and the competency of the surgeon.

All of this illustrates a number of points. Thus, each resident had his own preconceived notion as to why the patient was crying. Each revealed his own fears, were he to be in that position. Then, each lost his objectivity and confused the patient with himself; he projected onto the patient his own fears and fantasies. The correct answer would have been to have asked the patient why she was

crying and to have proceeded from there. One should have been prepared, under those circumstances, to give the patient fifteen or twenty minutes to discuss those things that most bothered her about her situation. It takes that length of time for a patient to go from the shock of the situation to some underlying fears. There are several dangers in what the residents might have done. One is that a patient might have been made aware of a contingency that she had not even considered and that this would only intensify her anxiety and depression. Refer back to our original model—that the transference to the physician includes some amount of regression and infantilization. Then we can explore the meaning to the patient of a doctor introducing and projecting his own fears on to the patient. What this says to the patient in effect is, "I know better than you do what is bothering you or should be bothering you." Such an omnipotent approach encourages further regression and ultimately a poorer response to what already seems to the patient to be an overwhelming situation. The exact situation applies in psychiatric and psychoanalytic treatment. Great care must be taken if one sets out to reassure the distraught patient. One should seek the patient's associations and realize that the greatest reassurance lies in (a) the existence of a positive transference and (b) in the patient feeling understood by a correct and documented interpretation. A reassuring speech carries with it a tendency for the therapist to identify with the patient and to project his own fears into the situation, all of which may or may not be disruptive.

Anxieties in people reflect early childhood experiences, conceptions, and misconceptions. The average physician does not know what the patient's early childhood experiences were and thus does not know his exact transference role, nor the direction of the patient's regressive tendencies, nor those areas where repression has been successful. It is, therefore, essential for him to *listen* to his patient in order to know what fears are consciously perceived and which require reassurance. This is different from allowing the patient a verbal

catharsis, which implies listening to anything that the patient says without particular response. Rather, there are realistic fears that can be dealt with, to a greater or lesser degree, if one learns in which direction the patient's experiences lie, which means taking time to listen to the patient.

A physician should not treat intimate family members, lest he lose his objectivity. A similar situation occurs when a physician is overly involved with (or even overly sympathetic to) a patient, thus identifying himself with the patient. This may or may not apply to friends or patients with whom the physician has become very close over the years. In terms of the model that we have discussed, what may happen is that the physician truly feels like a parent and the patient senses the reaction in the physician and in turn reacts to that. Then a symbiotic union is formed rather than a helpful patient-doctor relationship. Consequently, a physician in any specialty must be very introspective and assess his counter-transference to the patient whenever he is treating someone toward whom he has particularly strong positive or negative feelings.

Where we have encouraged the omnipotent role of the physician, any therapeutic failure, despite the most expert medical care, leads to enormous patient disappointment and hostility and projection of blame onto the "all powerful" physician. One way to minimize such hostility is to respond positively to requests for consultations. Such a consultation legally protects the physician. It also affords the physician an opportunity to teach a number of things to his patient. My remarks first will apply to the process of referrals to doctors in specialties other than psychiatry. Explanation as to the choice of consultant is most important. Patients do not take for granted that our choice of consultant is based largely or solely on the consultant's skills. They tend to wonder (consciously or unconsciously) whether friendship for another physician leads to a specific referral. The best surgeon to do an appendectomy may not be the best qualified to do a mastectomy. I have found

that patients appreciate our thoughtfulness and our attempts to find the consultant best equipped to handle a specific problem. I have always discussed the qualifications of a consultant and why I specifically chose that person when I have made a referral.

If a patient whom I was treating wanted a consultation because he felt not enough progress was made, I would encourage this but would suggest that he see someone of at least equal stature and preferably someone with more experience in relation to his specific problem. This approach helps humanize the doctor and tends to minimize the infantile dependent transference.

A more vexing and difficult problem concerns referral by the internist of patients with psychiatric problems. There have been various estimates concerning the proportion of functional disorders coming to the internist's or general practitioner's office. Estimates range from 40 to 80 per cent. Theoretically, most of these patients might profit from psychiatric help. But practically, that would be an impossibility. The field of providing psychological help is complicated. There are social workers and psychologists with varying amounts of training, psychiatrists, child psychiatrists, psychoanalysts, and child psychoanalysts, all doing therapy. There are endless arguments between various groups concerning the advisability of medical training as a background for psychological therapy. It is my personal conviction that a medical background is of great assistance in the treatment of the emotionally disturbed. Psychosomatic reactions are almost always present, and the therapist's knowledge of medicine is of constant value. The referring physician should know and take the responsibility for the type of referral he is willing to make. In my community, members of the Psychoanalytic Society (the group with which I am most familiar) see a certain number of psychiatric consultations each week even though they themselves do not have the time to treat new patients. A skilled psychiatrist or psychoanalyst in any community will know the strong and weak points of his colleagues and which

therapists work best with certain age groups or with certain types of psychopathology. Thus, an internist may profit from developing a relationship with a psychiatrist whose judgment he trusts, who will serve as a clearing house and who will screen and place his patients appropriately. The internist reciprocates by evaluating the psychiatrist's patients who, for example, may be hypochondriacal or whose complaints may be psychosomatic or conversion reactions. Such cooperation and mutual learning are highly desirable for the welfare of the patient and the edification of all involved. Psychiatrists, too, develop a relationship with colleagues in other parts of the country to whom they can refer patients moving to new communities. This is not an insignificant benefit from attending national specialty meetings.

Serious transference problems can develop with consultations, if overt or covert competition develops between the several physicians for the primary management of a patient. Equally disastrous is a situation where neither physician wants to assume primary responsibility. In each situation of joint involvement, one physician must bear the major responsibility for the management of the patient and must serve a liaison function. When this responsibility is transferred, the patient should be so notified.

A patient suffering from diabetes mellitus developed severe diabetic retinopathy and was referred to an ophthalmologist by his internist. The ophthalmologist in turn referred him to a retinal specialist who treated him with a lasar type of therapy* to ablate developing aneurysms in retinal vessels. Despite the treatment, the disease progressed. This specialist told him of two other specialists with whom the patient then consulted. Each had a different opinion about further treatment. The patient, who knew of me through a friend, called for a consultation. He felt anxious and depressed. Despite the obvious and realistic fears of impending blindness, his more immediate concern (which he had to be helped to recognize and verbalize) was that of utter helplessness and confusion in the presence of

so many specialists. He needed someone to integrate the various opinions. I spoke with his internist concerning the necessity of having one person collect the data, who, with the patient, would decide on appropriate treatment. The internist chose another ophthalmologist who agreed to do just that, and the patient's acute anxiety melted away.

Similar situations arise in the treatment of psychosomatic patients. In recent years, more psychiatrists and psychoanalysts have been treating psychosomatic patients suffering from illnesses such as asthma, ulcerative colitis, migraine headache, and so on, using dynamic psychotherapeutic measures alone. Results have been excellent and have paralleled those reported by Sperling³.

Psychosomatic patients tend to form markedly infantile and dependent relationships. They like to attribute this to being physically ill, but investigation of their pre-morbid states, reveals that similar dependent, infantile relationships always were present. The handling of the transference of a psychosomatic patient is very tricky and if the transference is mishandled or even if the vicissitudes of it are unrecognized, severe exacerbations of the somatic complaints may result.

Let us examine what at first may seem paradoxical. If the transference becomes negative (that is, if a patient distrusts, dislikes, or disrespects his physician) his psychosomatic illness can worsen. If he becomes very involved libidinally with his physician, over-values him, and endows him with magical qualities, his physical condition similarly may worsen. Either extreme produces a transference impasse. Psychosomatic patients use body language to express rage because they are in great fear lest they destroy objects by direct rage, and because the very objects they hate, they also need. Consequently, rage is expressed symbolically, masochistically, and magically. Thus, when such patients have strong negative transference feelings toward an internist, a gastroenterologist or a psychiatrist the result often is physical symptom exacerbation.

On the other hand, due to the primitive nature of such patients and their early fixations, unconscious phantasies toward loved objects are regressive and have many perverse elements. When the very friendly physician is viewed as seductive by the psychosomatic patient, the patient wards off this "seducer" by becoming ill. As the illness wards off the sexualized object, it also brings the object closer because the sick patient needs nurturing. With active disease, the patient feels safe because he has regressed *via* his illness. He is at oral or anal levels and thus has avoided phallic striving and the oedipus complex.

I wish there were some way to advise physicians as to how to achieve the perfect balance between closeness and distance, between human concern and professional objectivity. There is no single level to delineate, since each person is so different that what one patient perceives of as seduction another may feel to be rejection and *vice versa*. Yet this very concept may be helpful to our non-psychiatric colleagues. For example, weekly sigmoidoscopy of a colitis patient is often viewed by the patient as a seduction. Such procedures can be psychologically traumatic and perpetuate the condition of the patient. Following our model, such patients, to avoid feeling seduced, may regress and either act more infantile or develop more somatic symptoms.

Sperling, Deutsch, and Mintz² have reported on the need for primary psychiatric management of the psychosomatic patient undergoing psychoanalysis or dynamic psychotherapy. Those who have had special training in the treatment of such patients (as for example, the members of the Postgraduate Study Group on Psychosomatic Diseases of the Psychoanalytic Association of New York) realize the need to institute normalness: normal diets, normal activities, and elimination of drugs, as soon as feasible. Drugs, for example, are replaced by the therapeutic alliance and positive transference without which one cannot and should not attempt to effect such replacements. The positive transference must

be enhanced and should not be split any more than is absolutely necessary. To split the transference between two or more physicians causes confusion and further regression. This is particularly true since the patient associates the internist with drugs, restrictions, and hospitalization. The trained dynamic psychiatrist seeks to strengthen ego functions, thus to increase the patient's feelings of self-esteem and personal responsibility.

To illustrate this consider the following:

A woman at age 34 consulted me because of severe ulcerative colitis. She had been ill with this for ten years. During this period, she had seen the same internist. An acquaintance of hers had been successfully treated for this by a psychoanalyst and she suggested that the patient consult him. After such consultation, the patient was referred to me for treatment. The internist told the patient that he had no objection to her seeing me but warned her not to see me when she was in an acute phase lest I upset her, nor to go too often lest the intensity aggravate her illness, and to continue to see him once weekly. Whenever the internist saw the patient, he sigmoidoscoped her. Her husband, who was a dentist, often accompanied her and the internist frequently would call him in during sigmoidoscopy to show him the condition of the mucosa. The patient wore diapers during acute exacerbations, which at times were changed by her mother. When she came to my office, she wore two pairs of cotton panties and a pair of rubber panties on top. During the early phase of treatment, we discussed how she was using her body, by bleeding or with diarrhea, in order to deal with frustrating situations. Such interpretations had a salutary effect and she stopped bleeding. However, her weekly visit with the internist invariably led to some exacerbation of the diarrhea. He would attack my work by juggling her drugs based on the number of stools that she reported and by lecturing her about the inherent weakness in her body. Although he constantly devaluated the psychoanalytic approach, he made frequent suggestions of a manipulative nature, such as that the patient take a vacation away from her husband or away from her mother in order to decrease stress. It soon became apparent to the patient that, on the one hand he was attacking psychoanalysis, and on the other hand was indicating that psychogenic factors played a major role in her illness and that he wished to treat the psychogenic factors by home-spun advice and organic methods. I was very patient with her and pointed out repeatedly how she used the orientation of the internist as a way of reinforcing her illness and denying its psychogenicity. She appreciated the fact that I was not personally threatened by the internist, but rather interested in helping her. She finally asked me for a medical referral. I gave her the names of several internists who were interested in this disease. She chose one who, coincidentally, was known to her family and she subsequently remained with him. He and I discussed the medical management, and he agreed that repeated sigmoidoscopies were unnecessary. He told the patient that, barring difficulties, he did not want to see her more frequently than once a month and that later he would see her much less frequently. As soon as the change of internist was made, there was an alteration in the patient's general behavior and

demeanor. There was much less infantilization and she began to drive to appointments alone rather than having her husband bring her. We discussed the meaning of her wearing rubber panties, which she discontinued shortly thereafter. The patient's treatment was very rewarding. The splitting of the transference with the original internist was a resistance that had to be worked through before treatment could become meaningful. I shall not discuss the details of her subsequent successful treatment.

The medical management of this patient had led to regression because the first internist took an untenable position, namely that he, not the patient, could cure or at least control the patient's disease. The difficulty with such a position is that an intense, ambivalent transference developed, based on the patient's earlier relationships to parents seen as omnipotent. When the patient became angry with him, as when he had her husband observe her colon, the patient retaliated by exacerbation. This enabled her to defy the internist, to demonstrate his impotency and at the same time to retain a dependent relationship. Since such sick patients have oral and anal fixation, when the transference is split between one physician offering drugs and infantilization and another physician encouraging the development of self-esteem, personal control, and frustration tolerance, this type of patient becomes involved with the "magic" and does not work effectively psychotherapeutically.

Another inherent danger in the joint management of psychosomatic patients is based on the very nature of the doctor-patient transference. Children have two parents and normally play one off against the other. Regressed adults, particularly those with psychosomatic illnesses enjoy perpetuating this game by playing off internist against psychiatrist. If there is rivalry between the physicians, these patients sense it and exploit the situation. If there is no rivalry they try to create one by subtle provocative measures. Typically, such a patient will make an appointment with his internist or take medication without discussing it in psychotherapy. If physicians are aware of these maneuvers, they insist that all moves be out in the open. Barring emergencies the psychiatrist will not unilaterally discontinue medications without

prior consultation with the internist, nor will the internist institute major medical procedures, prescribe tranquilizers, and so on, without prior consultation with the psychiatrist, if the tendency to play one physician off against the other is to be frustrated for the patient's ultimate benefit.

Discussion

One can delineate what is conscious from what is unconscious in human thought. This is called the "topographic" approach. Another way of viewing behavior is by ascertaining the basic conflicts confronting a person; this is known as the "dynamic" approach. Still another avenue of exploration concerns itself with childhood experiences leading to current conceptions or misconceptions. In this instance we seek the "genesis" of the conflict. Often we review functioning in terms of energy distribution. Psychic energy is not of infinite quantity and thus lethargy and disinterest may represent limited available energy in one sphere due to excessive involvement or preoccupation in other spheres of interest. Here we speak of an "economic" approach. The "structural" point of view describes functioning by examining certain psychic agencies in the mind, the "ego," the "id" and the "superego." Further, the relationship each has with the other psychic agencies and with external reality can be explored. Finally, the "adaptational" point of reference deals with functioning as it leads to and permits adaptation for the individual and to his specific environment.

Freud¹ first described how human beings have a proclivity for transference relationships when dealing with meaningful persons. Such transference relationships are complex, based on earlier experiences.

Any physician is dealing with an unknown quantity when working with a new patient. Any astute and sensitive physician who has worked with a patient for a number of years has learned a great deal concerning the metapsychological structure of that patient, whether or not he separates the various com-

ponents of the patient's psyche. It is hoped that physicians will make themselves more cognizant of transference reactions and that the importance of such reactions in general medical cases will be appreciated. The unique role of the physician has been described to demonstrate how it leads to intense transferences. There is a normal tendency for a person in such a transference situation to tend to regress; unfortunately this regression often goes unnoticed by patient and physician. However, in the presence of medical failure or disappointment by the patient in any aspect of his treatment, regression frequently becomes evident as intense hostility. Since we cannot guarantee success or satisfaction despite the most expert and conscientious care, it is essential for the welfare of the patient and doctor to minimize such regressions. Whereas much of what has been presented would be a part of using "good common sense," it is my belief that understanding the principles involved in the doctor-patient relationship (as well as the inherent dangers in unknown transference relationships) is of the greatest importance.

Discussors

Milton Shoshkes, M.D., Millburn

We internists are qualified to treat the somatic aspects of disease. But we are uninstructed and unprepared to treat the deeper emotional problems of the patient. The average internist estimates that 40 to 60 per cent of his day is spent with patients driven to seek help because of basically functional disorders. Thus, the physician will dispense advice and a wide variety of medication which, he assumes, will interrupt and even erase these uncomfortable complaints. Thoughts of transference, let alone counter-transference, probably never enter his mind.

An internist who has not personally had psychoanalytic instruction (or therapy) has but the vaguest notion of the implications of the title of Dr. Deutsch's paper, let alone the content of this presentation. What separates

the internist from learning psychiatric therapeutic skills is a definite and almost tangible barrier that blocks the average practitioner from probing into the deeper psychiatric understanding of disease, of how emotions can be trouble, not only to his patients but to his own relationships to his patients in his practice. There is a frank hostility to understanding the psychoanalytic theory as related to the dynamics of disease. This peculiar resistance to the understanding of the contributions that psychoanalysis makes to the understanding of human behavior is profound and widespread among nearly all of my peers. I cannot offer a satisfactory explanation as to why this intolerance to psychoanalysis as well as other methodologies of psychiatry exist, but I am certain that your group could propose some better insight into this troubling problem. As example of this general resistance of the clinician to exploring the psychiatric understanding of disease. I must cite my experience of four years ago, when, with the great help of Albert Silverman, M.D.†, we devised a training course in psychosomatic medicine. We mailed applications for this to every generalist and internist in New Jersey, totaling 1500 names. Only four indicated their possible interest, and this venture was dropped. As another frustrating example, I can recall futile hours spent trying to convince excellent gastroenterologists that ulcerative colitis is basically an emotional disorder. Despite the patent personality defects that glared in their patients, these gastroenterologists preferred to invoke the etiology of a bacillus or an unclassified virus instead of the more subtle emotional origin of this illness. Much groundwork needs to be done before internists can be reached by these concepts of an unconscious mind wreaking its havoc on a body organ.

The comprehension of transference is urgently required by the internist. The internist is functioning as the intimately involved primary physician who treats families rather than the distantly separated cold consultant of the 1930's and 1940's. Transference forms the basic strength of such a practice. This in many ways can resemble that of a psychiatrist in

†Then Professor of Psychiatry at Rutgers.

that it requires the gentle uncovering of repressed and turbulent emotions. When this uncovering occurs negatively, the anger induced can erupt into a rage directed to the physician, even to the point of precipitating a malpractice suit. Many of these malpractice suits might be considered evidence for my statement confirming that the witless provocations by the unskilled or unconsciously brutal physician tampering with the hidden rages of the patient has created this retaliation as the only way the patient has at hand to act out. The physician is usually surprised that these eruptions are focused upon him for he has, to his own knowledge, attempted to do what he thought "best for the patient." Certainly, obtaining consultations, as urged by Dr. Deutsch, could have helped to abate some of this emotional outburst. However, this kind of physician usually wishes to dominate the therapeutic drama, and will stick to his lonely position despite its rapidly increasing hostile isolation. Unfortunately, imperious and god-head like wishes exist in many dominating internists. These physicians have no concept of the fact that they are as vulnerable as they are imperious. Such an example is that given by Dr. Deutsch of the internist who sigmoidoscoped a palpitating and bleeding rectum weekly: a totally unnecessary function. This type of physician can overwhelm, injure, and destroy a withdrawn and frightened subject, who has been exposed to a similar omnipotent and threatening figure in her childhood. I am currently reminded of a gentle 55-year old woman who literally trembled when she visited me professionally. This trembling was so marked that her electrocardiograph was a conglomeration of extraneous muscular movements superimposed upon the usual tracing. I met her first at the bedside of her husband whom I had treated for an acute myocardial infarction. In the course of our gradually developing relationship, she explained that she, her husband, and her children "never went to doctors." They had avoided the standard protection of inoculations required for the prevention of the usual contagious diseases. Her admission was uttered boastfully, perhaps as a defensive maneuver to conceal her own confusion as to

how to explain her obvious dereliction of standard health protection that she denied to her family. After one whole year of trembling in my presence, she was finally able to state (in a self-discovery fashion) that I somehow seem to remind her of her father in that she recalls experiencing the same type of fear when she was somewhere near his presence. This man frequently brutalized her elder siblings in her large family, although he rarely struck her. Yet, she would remember trembling under the covers of the bed whenever she heard his terrorizing footsteps stomping about the lower floor. She realized, of her own insight, that what she was experiencing was a transference to me, her internist. This rather broad example, simple enough for the psychoanalyst to understand, is repeated in some degree by each patient who sits across our desk.

Problems in counter-transference are not as well covered by Dr. Deutsch's excellent paper due to the limitations of time. I hope he will enlarge on this soon. These involvements with our patients are of the utmost importance, and can predetermine the success or failure of many serious therapeutic problems facing the physician. The ego-strength of the internist is a fragile thing, no matter how respected and well-trained he might feel himself to be. It can be easily strained by the querulous complaints and inferences of inadequacy that are often voiced by the chronically ill patient who already is frightened and often emotionally disturbed because of his increasing awareness of serious and chronic illness. Because of this emotional strain (which can be intolerable) errors of judgment can be stimulated. This might be, for example, the use of an unnecessary biopsy or the ordering of a risk-inherent diagnostic procedure such as interarterial x-ray studies or cardiac catheterization studies that might not be entirely necessary for the working diagnosis, or even the dramatic intervention of exploratory surgery. These diagnostic procedures are called upon as defensive maneuvers and even, conceivably, as punishment for the offending patient. We also see the moralistic censoring that many physicians

unconsciously use to determine the extent of their sympathetic involvement and even the carefulness of the diagnostic evaluations of the problem involved. Censoring might arise in the treatment of an alcoholic. Alcoholism, in the mind of the physician, might be classified as a type of indefensible self-induced illness in a worthless individual. The drug-addicted patient will often appear as a rather woebegone and unsympathetic individual who will receive short shrift from the accusatory physician playing the role of prosecutor and judge as well as therapist. These also might include the racially or religiously prejudiced physician, who will unconsciously distribute his talents variably according to those he identifies with the most, and restricts his efforts for those against whom he is prejudiced. These examples are important aspects of counter-transference, more so than the provocative thought of sexual entanglements that are usually adequately handled in a defensive fashion (whether crudely or with elegance) by most internists.

I hope that we are beginning what will probably be a disappointingly slow and tedious process of teaching the internist and generalist some of the basic concepts of psychoanalytic understanding of the interrelationships between a doctor and his patient. I urge a girding of the minds of the missionary analysts against future disappointments that will surely occur. Success will be hard won and only after many years of often disillusioning trial.

Paul F. Syracuse, M.D., Irvington

The transference concept has always been a rather complicated phenomenon. It is defined, in a psychoanalytic glossary as "the displacement of patterns of feeling and behavior, originally experienced with significant figures in one's childhood to individuals in one's current relationships."

Perhaps the outstanding work in transference in psychosomatic patients with such severe illnesses as ulcerative colitis, migraine, asthma, and some dermatological conditions is by

Dr. Melitta Sperling, with whom Dr. Deutsch has worked. Her contributions should be required reading for any modern day medical student, teacher, and practitioner. Her work has advanced the psychiatric understanding enormously and has led to the formation of several graduate study groups on psychosomatic disease. The psychiatrist can now successfully treat severe somatic illness where the etiologic roots are more increasingly being delineated as functional. Dr. Deutsch's case of the 34 year old woman with ulcerative colitis gives us ample evidence of this; it also points up the problems inherent in the joint management of the psychosomatic patient by the psychiatrist and internist. Where there are frequent visits to the internist, along with visits to the psychiatrist, the patient will be in a difficult position; frustrated by the lack of personal contact with the therapist, the patient places the internist in the special position of being the object of this frustration. This can be a very heavy burden for the physician and, as Dr. Deutsch pointed out, can manifest itself in the form of anger, seductiveness, ambivalence, or excessive regression.

Here is a brief account of a case in which there was a pre-existing transference to the internist, resulting in a split in the patient's psychic energies between the internist and myself. She was a 16-year-old girl with an eight month history of ulcerative colitis. She was referred by her pediatrician following hospitalization, her third. Before starting psychotherapy she had been in treatment with an internist who instituted the standard organic regimen for this illness. There was little improvement and he felt surgery was indicated. At this point, the patient's pediatrician (who had previous good results with other psychosomatic patients treated psychiatrically) felt that psychiatric consultation was in order.

What I saw was a talkative, bright, open adolescent, not very troubled about her illness. This was reminiscent of the "belle indifference" so frequently seen in the hysteric

personality. Generally speaking, she was a neurotic character with various phobic, obsessive, compulsive, and depressive features. The acute, sudden somatic symptoms gave her a way of avoiding these and other deeper problems essentially related to separation anxiety. There was no indication of psychosis but the defenses in such patients frequently suggest a psychotic organization. The regressive pull and primitiveness of their defensive operations might reinforce such an impression. The patient was only moderately motivated to start psychiatric treatment.

As therapy progressed she became mildly aware that there was a connection between her illness and her emotional life, that certain conscious problems she had with her family and in school "made her condition worse." She began to understand that the colitis was "a form of body language which enabled her to express strong feelings and impulses immediately without being consciously aware of them." I attempted to help her recognize and tolerate these impulses and to express them verbally. But there was a marked reluctance on her part to get well. She had a strong positive transference to the internist. She was making weekly visits (many included sigmoidoscopy) without mentioning it to me in the therapeutic hour. She felt the internist to be an omnipotent figure who knew best and who knew more about this disease than anyone in the world. This feeling toward the internist was a repetition of her feeling toward her father, a man who had never been wrong about anything. The transference distorted her perceptions and made the internist the recipient of many powerful feelings she could not tolerate consciously toward her father but, to some degree, could toward the internist, the less incestuous object. I could also see why she had the negative transference to me and why she was "Keeping secrets." It was to protect the alliance with the internist-father. As long as this situation obtained, psychiatric treatment would be difficult, and as long as the internist was unknowingly the object of the transference the psychiatric treatment was impossible.

Clearly there was a problem of split transference to be dealt with. With the patient's knowledge, I arranged a meeting with the internist where I shared with him the significant data of her past family and developmental history, spelling out how these genetic factors contributed directly to her illness, the fears, and phobic formations. I explained the transference relationship to him and how tricky it would be for him to maintain a neutral position with her. He then saw how his actions were being construed by her to suit her emotional needs. I also hoped as did Dr. Deutsch, that the internist would keep the sigmoidoscopy and medication to an absolute minimum; he was, of course, to maintain necessary medical supervision. The internist was then able to alter his position somewhat. Psychotherapy progressed and the deeper implications of the transference problems were explored with the patient.

At a later date when the possibility of surgery was suggested, the patient sought a second medical opinion. The consulting internist had seen the successful psychiatric treatment of this kind of case and encouraged the patient in this direction; the psychotherapy, though still in the early phases, had begun to make more available to the patient an understanding of many aspects of her relationship to her father. She then elected to have this internist take over the medical management of her colitis. He agreed to take the patient on and (perhaps understanding the complexities of the patient's transference to the physician) maintained a reasonable medical supervisory position. It is interesting to note, also, with what speed the patient sought out a third internist at this moment to back up the other consultant in order to fill the emotional void created at the threatened loss of the first father-internist figure.

Dr. Sperling's work has opened new avenues of treatment for the psychiatrist; patients can now be treated who once would not have been treated psychiatrically at all or would have been treated with poor results. Dr. Deutsch has shown us how patients establish different kinds of relationships with the

physician and how complicated these relationships become when two physicians are involved. I have attempted to illustrate in my discussion just how real and desperate is the need of the patient to form these attachments.

Dr. Deutsch disproves Shaw's adage, "*He who can, does, he who can't, teaches.*" Dr. Deutsch does both and very well indeed. He has

eloquently taught us today what he's beautifully and effectively done in his treatment of the psychosomatic patient.

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301 Broad Avenue (Dr. Deutsch)
116 Millburn Avenue (Dr. Shoshkes)
40 Union Avenue (Dr. Syracuse)

The Second Most Prevalent Disease

Gonorrhea ranks second to the common cold as the most prevalent communicable disease in the United States. Every fifteen seconds someone is infected with gonorrhea. Since 1965, the incidence of gonorrhea escalated by about fifteen per cent per year. For the last six months of 1970, it is estimated that the rate of gonorrhea soared to 315 per 100,000 population. These figures (from the U.S. public Health Service's Center for Disease Control) are only the *reported* cases. CDC estimates that about four times as many people or more than two million were treated for gonorrhea in 1970. Also, many others have the disease and transmit it through sexual contacts. However, many women don't develop symptoms and, therefore, don't go to doctors for treatment.

WHO's Pan American Health Organization reports that the U.S. has the sixth highest rate of gonorrhea in the hemisphere. Based on 1969 figures, latest available for individual countries, PAHO reports that Canada is thirteenth highest with a 129 per 100,000 population incidence rate, while the highest gonorrhea rates are from the Caribbean. Jamaica's rate of 2147 per 100,000 population leads. In Europe the incidence of gonorrhea is also increasing. Although venereal disease rates of all types are rising throughout the world, it

has been labeled as reaching "epidemic proportions" in the U.S.A., with gonorrhea "clearly out of control." *Reported* gonorrhea rates are highest in the 20 to 24 age-group (1,412 per 100,000 population in 1969). However, the 15 to 19 age-group has the most rapidly increasing incidence (20 per cent climb in 1967, 19 per cent jump in 1968, and another 19 per cent hike in 1969). It seems that the organism is becoming more resistant to penicillin and other antibiotics traditionally used to treat gonorrhea.

Changes in birth control practices have had a substantial impact on the increasing rates of all venereal diseases, some experts believe. WHO estimates that in the Western world 17.5 million women were taking oral contraceptives. Changes in modern life styles have given preference to the pill and intrauterine devices over the condom, which is not only a birth control device but a VD preventive as well.

Dr. Arthur E. Callin, chief of the PAHO U.S. VD branch's program services section, says that "gonorrhea is a multi-million dollar liability to the U.S.A." taking into account the costs of tests and physicians' services, along with time lost from work. Controlling VD, he adds, is a "profitable public investment."



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Although PYOPEN (disodium carbenicillin) is indicated primarily in Gram-negative infections, its activity against Gram-positive organisms should be kept in mind when both Gram-positive and Gram-negative organisms are isolated (see Actions). **Note:** During therapy, sensitivity testing should be repeated frequently to detect the possible emergence of resistant organisms. **Actions:** Organisms found to be susceptible *in vitro* include: Gram-Negative Organisms—*Ps. aeruginosa*, *Proteus mirabilis*, *Pr. morganii*, *Pr. rettgeri*, *Pr. vulgaris*, *E. coli*, *Enterobacter* species, *Salmonella* species, *Hemophilus influenzae*, and *Neisseria* species. Gram-Positive Organisms—*Staphylococcus aureus* (nonpenicillinase-producing), *Staph. albus*, *Diplococcus pneumoniae*, Beta-hemolytic streptococci, and *Streptococcus faecalis*. Some newly emerging pathogenic strains of *Herellea*, *Mima*, *Citrobacter*, and *Serratia* have also shown *in vitro* susceptibility. Not stable in the presence of penicillinase. *Klebsiella* species are resistant. Some strains of *Pseudomonas* have developed resistance fairly rapidly. **Contraindications:** Known penicillin allergy. **Warnings:** Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, appropriate therapy should be instituted and discontinuance of disodium carbenicillin therapy considered, unless the infection is life threatening and only amenable to disodium carbenicillin therapy. The usual agents (antihistamines, pressor amines, and corticosteroids) should be readily available. **Usage in Pregnancy:** Safety for use in pregnancy has not been established. **Precautions:** As with any other potent agent, it is advisable to check periodically for organ-system dysfunction, including renal, hepatic, and hematopoietic systems, during prolonged therapy. Emergence of resistant organisms, such as *Klebsiella* species and *Serratia* species, which may cause superinfection, should be kept in mind. Each gram contains 4.7 mEq sodium; in patients where sodium restriction is necessary, such as cardiac patients, periodic electrolyte determinations and monitoring of cardiac status should be made. Observe patients with renal impairment for bleeding manifestations and adhere strictly to dosage recommendations. If bleeding manifestations appear, discontinue antibiotic and institute appropriate therapy. As with any penicillin preparation, the possibility of an allergic response, including anaphylaxis, may occur, particularly in a hypersensitive individual. **Administration:** Intramuscular injections should be made well within the body of a relatively large muscle (not into the lower and mid-third of the upper arm), and aspiration is necessary to help avoid inadvertent injection into a blood vessel. May be given by either intravenous injection or intravenous infusion. After reconstitution with Sterile Water for Injection unused portions should be discarded after 24 hours if stored at room temperature, or after 72 hours if refrigerated. **Adverse Reactions:** Hypersensitivity Reactions—Skin rashes, eosinophilia, pruritus, urticaria, drug fever, and anaphylactic reactions. Gastrointestinal Disturbances—Nausea. Hemic and Lymphatic Systems—Hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, in uremic patients receiving high doses (24 gm/day), hemorrhagic manifestations associated with abnormalities of coagulation tests, such as clotting and prothrombin time. Hepatic and Renal Studies—SGOT and SGPT elevations have been observed, particularly in children. To date, no clinical manifestations of renal disorders have been demonstrated. Central Nervous System—Convulsions or neuromuscular irritability could occur with excessively high serum levels. Local Reactions—Pain at the site of injection, sometimes accompanied by induration. Vein Irritation and Thrombophlebitis—particularly when undiluted solution is injected directly into the vein. **How Supplied:** Available in 1 Gm. and 5 Gm. vials.

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I hear questions about the three billion or so dollars spent by the drug industry in research during the past ten years . . . working on new and better drug products. It does seem like quite a bit of money to spend, and I realize some of it goes into dead ends. That's the problem with research, any research . . . you often don't know where you're going until you get there. I want all the tools I can get to help my patients. I want more drugs and more effective drugs. If they mean less pain, longer lives and more productive careers for those I treat . . . well, that's what really counts.

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

September 19, 1971

A regular meeting of the Board of Trustees was held on September 19, 1971, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Carrier Clinic Symposium . . . Concurred in the action of the President which gave official permission for use of MSNJ's name as a co-operating agency sponsoring the eleventh seminar in the series, "Psychiatry for the Physician," to be held on October 6, 1971.

Comparative Medicine-Human Health Series . . . Noted that once again MSNJ is listed as a cosponsor of the annual program in the series titled "Comparative Medicine-Human Health," to be held in North Brunswick on October 6. Dr. Edwin Albano continues to be the Society's representative and a collaborator in the preparation of the programs.

Educational Credit for Society-Sponsored Programs . . . Directed that in the future all Society-sponsored programs of a scientific character that could be eligible for educational credit be presented to the Society at least two months in advance of the scheduled meeting so that the question of accreditation may be considered.

Council on Legislation . . . Approved the recommended position on the following bills of medical interest, with the noted exceptions on A-2451, A-2476, and A-2500:

S-2228—To establish the Aircraft Noise Control Act. *ACTION DEFERRED*, pending further information from the Department of Environmental Protection.

S-2260—To recognize the Department of Institutions and Agencies, replacing the Board of Control with the Board of Institutional Trustees; provides for appointment of the Commissioner

by the Governor and makes the Commissioner chief executive officer of the Department. *DISAPPROVED*, because this bill would retain mental institutions under the Department of Institutions and Agencies, and the Society supports establishment of a separate department of mental health headed by a licensed physician.

S-2272—To amend the New Jersey Controlled Dangerous Substances Act. *APPROVED*

S-2275—To prescribe requirements to which all prescriptions for controlled dangerous substances must comply under supervision of the Commissioner of Health. *DISAPPROVED*, because (1) although we support all intelligent and practicable means of controlling drug abuse, the volume of drugs made available to addicts through doctors' prescriptions is minimal, (2) the work entailed in keeping these records would involve quite a bit of time and expense, and (3) because present New Jersey and Federal Legislation are adequate enough to control this type of drug abuse.

S-2280—To repeal Sections 1, 2, 3, 4 & 5 of Chapter 102, P.L. 1952 concerning the Prevention of Chronic Illness Act. *NO ACTION*

S-2295—To repeal P.L. 1952, Chapter 230, requiring registration of certain persons convicted of crimes or offenses relating to the use, possession, sale, transportation or other dealings with any narcotic drug. *APPROVED*, LAW, C. 231 (1971)

S-2303—To authorize the State Board of Higher Education to contract with and provide compensation to any school of medicine listed in the World Directory of Medical Schools which has an enrollment of not less than 150 students who had been residents of New Jersey for at least 12 months prior to entering medical school, to furnish training in medicine to such students; appropriates \$1,500,000. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES*, because the money would be better spent to enlarge and equip the present two schools and to establish a third medical school in the State of New Jersey.

SR-2015—To create a commission to study methods of relieving the existing difficulties of the several health care institutions of Hudson County to provide more efficient management and adequate funding of such institutions. *APPROVED*

A-2389—To create a guaranteed medical education loan program within the Higher Education Assistance Authority. *APPROVED*

A-2417—To establish the Clean Ocean Act to regulate and control the disposal of waste in the ocean off the coast of the State and to authorize the Commissioner of Environmental Protection to adopt rules and regulations. *APPROVED*, LAW, C. 177 (1971)

A-2431—To appropriate \$11,725,208 to the Department of Institutions and Agencies from the Public Buildings Construction Fund for construction at the Greystone Park Psychiatric Hospital. *APPROVED*, LAW, C. 262 (1971)

A-2451—To provide for admission to examination for a health officer license any applicant licensed to practice medicine in New Jersey. *DISAPPROVED*, because it would reduce the present qualifications, with hazard to the public interest.

Note: The Board amended the recommended position of "disapproved" to *APPROVED*.

A-2452—To amend the Health Care Facilities Planning Act to permit consideration as public need, the needs of members of a religious body operating a health care facility. *NO ACTION*, LAW, C. 138 (1971)

A-2455—To amend the New Jersey Medical Assistance and Health Services Act to provide for a one year contract, renewable annually, between the State and an underwriter and fiscal agent to administer payment of claims under the Act and to prescribe information on expenditures to be maintained by the underwriter and fiscal agent. *NO ACTION*

A-2476—To provide that bioanalytical laboratories shall bill clients directly and not through physicians as middlemen. *APPROVED*

Note: The Board *DEFERRED ACTION* on the recommended position of "approved," pending a conference with sponsors of the bill.

A-2487—To permit boards of education to provide sex education in grades 7 through 12. *DISAPPROVED*, because sex programs should not be prohibited for pupils below the 7th grade, provided the programs and teachers are carefully screened and approved and parental approval is given.

A-2500—To provide for increased health manpower by giving the Board of Medical Examiners authority to develop and approve programs for training of syniatrists and to permit approved syniatrists to perform certain medical services under the supervision of licensed physicians or surgeons. *DISAPPROVED*, because of the danger that unqualified persons may be empowered to carry out medical procedures on patients.

Note: The Board amended the recommended position of "disapproved" to *APPROVED*.

A 2533—To appropriate \$10,000,000 to the Department of Education for drug education programs in elementary and secondary schools. *DISAPPROVED*, pending the findings and recommendations of AR-2018.

A-2537—To direct the Commissioner of the Department of Health to establish and operate a drug treatment center in conjunction with the Greater Paterson General Hospital, to be administered through the Division of Narcotic and Drug Control and to approve \$750,000 therefor. *APPROVED*

ACR-2040—To establish a commission to study conditions at Newark and New Brunswick campuses of the College of Medicine and Dentistry of New Jersey and proper location of north New Jersey campuses presently located in Newark. *DISAPPROVED*, because the proposal encourages delay and vacillation inimical to the prompt development of adequate medical school facilities under the auspices of the State of New Jersey.

AR-2018—To create a commission composed of 6 members of the General Assembly, no more than 3 for each party, to advise and assist the Department of Education in the development and operation of a drug education program in elementary and secondary schools of the State and to advise the Legislature on the progress of the drug education program. *APPROVED*

Council on Medical Services . . . Approved the report of the Council on Medical Services, including the following recommendations:

1. *Position Statement on Physicians' Assistants—*

That The Medical Society of New Jersey, recognizing the need for qualified persons to assist physicians in the delivery of good health care services to the people of New Jersey, approve and support the adoption of sound and innovative programs for the development and production of appropriate supportive allied health personnel, and support legislation that would remove presently existing legal restraints and thus promote the development and utilization of qualified allied health personnel, in accordance with the AMA guidelines.

2. *Legislation Concerning Medical Assistants (Resolution #9)—*

That, in light of the foregoing position statement on physicians' assistants, Resolution #9 (to effect enactment of legislation to legalize physicians' use of qualified allied medical personnel) be approved as to substance and intent.

3. *Physician Shortage and Physicians' Assistants (Resolution #18)—*

That the action of the 1971 House of Delegates in not adopting Resolution #18 be concurred in for the following reasons: (a) MSNJ is already clearly on record and active in encouraging the expansion of present medical schools, the establishment of new ones, the reduction of medical school programs to three cal-

endar years, and increased production of medical technicians; and (b) it has recommended that the Society support sound programs to make available the services of properly qualified allied health personnel, including physicians' assistants.

Note: At the time the Board voted to approve the Council's recommendation (see above) it directed that it be officially recorded that the Society approves the adoption of legislation to make available physicians' assistants and other syniatrists only on the basis of their being certified as qualified and not separately licensed.

4. *Restriction on P.L. 89-239 (Resolution #20)*—

That the action of the 1971 House of Delegates in not adopting Resolution #20 be concurred in because it is the opinion of the Council that it would be beyond the power of either MSNJ or the AMA to place limits on (or revert to the old format) the recent shift of emphasis under Federal law of the thrust of P.L. 89-239 and Regional Medical Programs—whatever its faults, RMP in New Jersey has achieved appreciable and significant results.

Long Range Planning and Development . . . Approved the report of the September 12 joint meeting of the Committee on Long Range Planning and Development, the Judicial Council, the Council on Medical Services, and the Committee on Medical Education, including the following recommendations:

That the Board of Trustees appoint a State Peer Review Committee consisting of at least five members, with an alternate for each member, and with each judicial district being represented. The Committee shall be given the authority to call consultants. Also, the Peer Review Committee is to be directed that its first responsibility is to devise guidelines for operation of peer review committees at state and county levels. Further, that the Board direct component medical societies to form peer review committees, subject in operation to the guidelines later to be supplied.

. . . Directed that the President and Chairman of the Board appoint the members of the above-mentioned State Peer Review Committee.

2. That the *ad hoc* task force suggested by the New Jersey Hospital Association (to explore the need for improving utilization review process in hospitals and possible demand by the State for information on quality of care being rendered in hospitals) be appointed and that Doctor Louis F. Albright be a member of that task force and be authorized to make further appointments.

State Board of Medical Examiners . . . Directed that the following (in alphabetical order) be submitted as candidates for appointment to the State Board of Medical Examiners, to fill the vacancy created by the resignation of Dr. John F. Kustrup, whose term would expire on December 5, 1972:

William Greifinger, M.D., Belleville
Raymond A. McCormack, Jr., M.D., Trenton
Emanuel M. Satulsky, M.D., Elizabeth

SAMA Representative at AMA Clinical Convention . . . Directed that MSNJ underwrite the expense (in the amount of \$225) of student participation on behalf of SAMA at the AMA Clinical Convention in New Orleans in November.

MSNJ's Employees' Pension Plan . . . Received and noted that IRS has approved the second amendment to the MSNJ's Employees' Pension Plan, which provides that employees with at least fifteen years' service be granted a minimum pension equal to fifty per cent of their average final compensation, less one-half of their primary Social Security benefit.

IRS Regulations Relative to Non-Related Income of Non-profit, Tax Exempt Organizations . . . Directed that the following communication from the Advertising Manager of *The Journal* be referred to Legal Counsel for study and interpretation of the new IRS regulations, as they may affect MSNJ.

On Monday of this week (September 13) in New Orleans at the State Medical Journal Advertising Bureau Convention representatives present were informed that the *Federal Review* of Saturday, September 11, published the new Internal Revenue Service Regulations relative to non-related income of non-profit, tax exempt organizations.

Mr. Karl Nygren (Kirkland, Ellis, Hodson, Chaffetz, Masters and Rowe of Chicago, Bureau's Legal Counsel) had discussed these new interpretations with General Counsel of the American Medical Association and their consensus is that each medical society will need to carefully review its legal and accounting procedures to publication income and expenditures.

All state medical journals operate at a deficit. Nevertheless, these publications may be subject to payment of taxes on advertising receipts, based on local interpretation by IRS representatives. As an example, the Nebraska State Medical Association has been assessed a tax for 1968 of \$2,900 and a \$700 tax for

the year 1969. Unless specific accounting policies are followed, advertising net income (advertising costs deducted from advertising revenues) may be non-related taxable income *even though* total publication costs exceed total publication income.

It is, therefore, respectfully requested that the Board of Trustees initiate a review by appropriate personnel and committees of its present policies in order to place The Medical Society of New Jersey in the most favorable position relative to its *Journal* advertising and other non-related income.

AMA Clinical Convention . . . Authorized the following (with expenses paid at a per diem of \$50) to attend the 1971 AMA Clinical Convention in New Orleans, November 28 to December 1: President, President-Elect, Executive Director, seven regular delegates; and seven alternate delegates.

Statewide Automated Bookkeeping, Accounting, and Billing System . . . Voted to recommend to the component societies the proposal submitted by Data Control, Inc., for the establishment and operation of a statewide automated bookkeeping, accounting, and billing system.

. . . Directed that this recommendation, together with supporting informative data, be supplied to the component societies and made available in advance to the presidents of component societies so that they may discuss the item at the forthcoming Conference of Presidents and Presidents-Elect in connection with the October 17 meeting of the Board of Trustees.

ATTENTION COMPONENT SOCIETIES

Please Note!

The 206th Annual Meeting of MSNJ will be held **May 6 to 9, 1972**. Please schedule your county meeting for election of delegates and alternate delegates so that the names can be forwarded to the Executive Offices no later than **April 1, 1972**.

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of August 12, 1970: Section 3685, Title 39, United States Code)

1. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

2. Date of Filing: September 22, 1971.

3. Frequency of issue: Monthly.

4. Location of known office of publication: 315 West State Street, Trenton, New Jersey 08618.

5. Location of the headquarters of general business offices of the publishers (Not Printers): 315 West State Street, Trenton, New Jersey, 08618.

6. Names and addresses of publisher, editor, and managing editor: Publisher, The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey; Editor, Henry A. Davidson, M.D., 315 West State Street, Trenton, New Jersey; Assistant Editor, Mrs. Marjorie Treptow, 315 West Side Street, Trenton, New Jersey.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.): The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: None (a non-profit corporation of New Jersey).

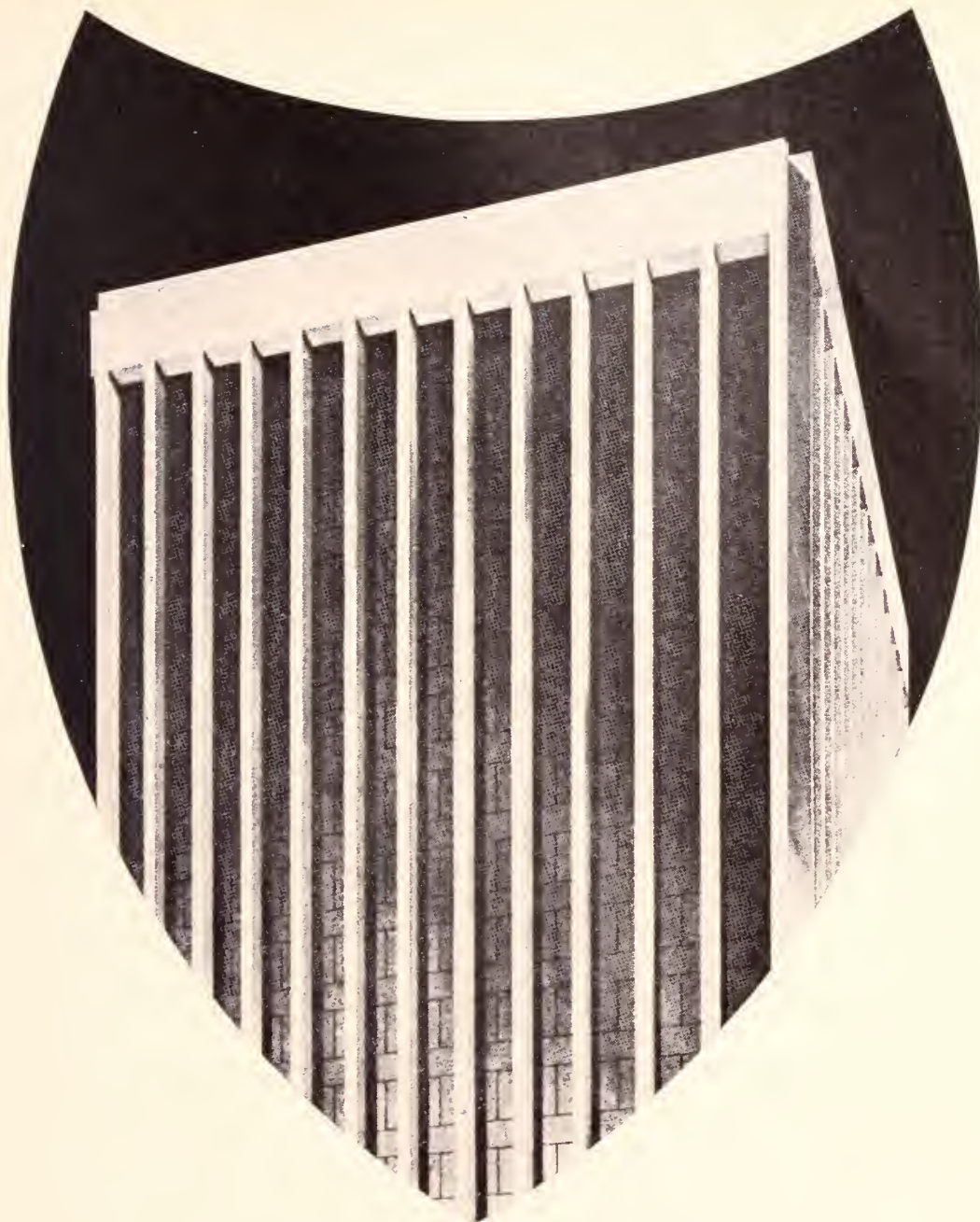
9. For optional completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4357 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates authorized by 39 U. S. C. 3636. (Signed: R. H. Lambert, Business Manager, The Medical Society of New Jersey).

10. For completion by non-profit organizations authorized to mail at special rates (Section 132.122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

11. Extent and nature of circulation:

	Average No. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total No. copies printed (Net Press Run)	8,752	8,800
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales	—	—
2. Mail Subscriptions	8,264	8,346
C. Total Paid Circulation	8,264	8,346
D. Free Distribution by mail, carrier or other means		
1. Samples, complimentary, and other free copies	356	330
2. Copies distributed to news agents, but not sold	—	—
E. Total Distribution (Sum of C and D)	8,620	8,676
F. Office use, left-over, unaccounted, spoiled after printing	132	124
G. Total (sum of E & F—should equal net press run shown in A)	8,752	8,800

R. H. Lambert, Business Manager,
The Medical Society of New Jersey



We've made a move to provide even better service to our 3.5 million subscribers and nearly 8,000 Participating Physicians.

Medical-Surgical Plan has moved to larger quarters which the Plan has leased in a new building at 33 Washington Street, Newark.

For some time the Plan has been overflowing its headquarters at 500 Broad Street, Newark, and has had to take additional space at several other locations, as personnel were needed to cope with increasing claims volume, with introduction of new programs and with more sophisticated operating technology.

Now all the Blue Shield operations have been pulled together under one tent.

This should further improve the efficiency of our operations, as well as costing us less, overall, for space, and allowing for further expansion when necessary.

We intend to give you the best possible service from our new home. Please be sure to use the new Physician Inquiry Unit telephone number — (201) 456-3250.

BLUE SHIELD 
Medical-Surgical Plan of New Jersey

NATIONAL HEALTH INSURANCE BILLS OF 1971

BILL TITLE - INTRODUCED BY DATE NUMBER	PARTICIPATION	BENEFITS	INSURER	PRIVATE CARRIERS' ROLE	SUPERVISION	AFFECT ON OTHER PROGRAMS	FINANCING AND ESTIMATED COST	MAJOR SUPPORTING GROUPS	EFFECTIVE DATE	PROVIDER PAYMENT	BILL'S STATUS	MISCELLANEOUS
"Health Security Act" Senate House Kennedy Griffiths Jan 25 S 3 H R 22	Compulsory	Complete hospital and medical; no deductible or coinsurance; dental for children; prescription drugs	Federal agency	Provide supplemental benefits. Upon qualifying, could provide bill benefits on prepaid basis as a professional foundation.	Health Security Board within HEW	Replaces Medicare and Medicaid	Federal government to pay 50% of cost, rest divided among employer/employee, self-employed and uninsured income. Cost: HEW estimate \$77 billion, Kennedy \$57 billion.	AFL CIO, UAW and Committee on National Health Insurance	July 1 after second calendar year of enactment	Physicians on capitation basis; institutions to meet approved budget.	Senate Finance and House Ways and Means Committees	Incentives for group practice, regional coordination of personnel and facilities, study and recommendations for long-term care and malpractice
"National Health Insurance Act" House Dingell Jun 22 H R 48	Compulsory	60 days hospital, medical, dental, prescription drugs, home nursing.	State agency or voluntary health plan contracted by the agency	Subject to contracts with state agencies	National Advisory Medical Council within HEW	Retain Medicare, replace Medicaid.	Employer/employee contributions under system similar to Social Security. No estimate on cost.	None at this time	Not specified	Hospital reasonable cost up to maximum; Physicians: fee-for-service, per case, per session, per capita, salary or combination of all	House Interstate and Foreign Commerce Committee	Grants to students and educational institutions for training in health occupations.
"Minimum Health Benefits and Health Services Distribution and Education Act of 1971" Senate Palf Mondale Feb 10 S 703	Compulsory	Medical and hospital up to 12 days after 2 day deductible, up to 10 days in ECF, maternity, outpatient services, drugs, catastrophic coverage subject to limitations prescribed by Secretary.	Community health and education corporations, private insurers or employer as self-insurer	Remain same.	Community health and education corporations regulated by HEW	Retain Medicare and Medicaid.	Employers pay for employees with small business exempt up to 5 years under certain conditions. Federal government pays for indigent on capitation basis to contracting health care corporations. No estimate on cost.	None at this time	Two years after enactment.	Dependent upon arrangements made by employer.	Senate Labor and Public Welfare Committee	Health corporations would be for-profit entities and would issue common and preferred stock, to inject regional competition for private carriers.
"National Health Care Act of 1971" Senate House McIntyre Burleson April 5 Feb 17 S 1490 H R 4349	Voluntary	To be phased in, in three stages to be virtually comprehensive for everyone by 1979. Coinsurance and deductibles subject to maximums determined separately under private and public plans	Private carriers and public pool.	Remain same with carriers partially underwriting high risk and medically indigent pool losses; state and federal governments pay rest.	Council of Health Policy Advisers subject to Senate approval	Replaces Medicaid, retain Medicare.	Workers, self-employed and non-poor pay for selves; federal/state payments for high risk and poor. No estimate on cost.	Health Insurance Association of America	Phased in, in three steps by Dec. 31, 1978.	No change.	Senate Finance and House Ways and Means Committees	Grants and Loans to increase health manpower and facilities, promote outpatient centers, authorize comprehensive health planning.
"National Health Insurance and Health Services Improvement Act of 1971" Senate Javits Feb 18 S 836	Compulsory. Employers and individuals may take an option to purchase equivalent or approved program offering better benefits	Hospital and Medical patented after Medicare, dental for children up to eight years of age, maintenance drugs. Some services subject to deductibles and coinsurance	Private carrier and state agency	Fiscal agent underwrite coverage.	HEW for state agencies, HEW selection for qualified private carrier.	Expand Medicare to all as alternative coverage.	Private: employer pays 75% of cost, employee rest. National: matching employer/employee/government contribution. 1972 government cost \$5.2 billion, up to \$22.7 billion by 1975.	None at this time.	Phased in by July 1, 1974	Remain same while developing alternate methods.	Senate Finance Committee	Incentives for developing comprehensive health service systems much like HMOs.
Health Care Insurance Act of 1971 "Medicredit" Senate House Hansen Fulton Feb 25 Feb 25 S 987 H R 4960	Voluntary	Institutional care \$50 deductible, medical, emergency outpatient: 20% coinsurance on first \$500; 100% catastrophic coverage after "expense corridor" met.	Private carriers.	Remain same.	Health Insurance Advisory Board within HEW	Retain Medicare, states have option to replace or retain Medicaid.	Income tax credits, based on tax liability; federal government payment for poor. Cost: \$12.1 billion in new money.	American Medical Association	June 30, 1971	No change.	Senate Finance and House Ways and Means Committees	Bill strictly a financial proposal.
"Health Rights Act of 1971" Senate Scott/Percy April 21 S 1598	Voluntary	Catastrophic plan: Inpatient catastrophic plan for hospital and psychiatric services. Also, dental care, nursing home and home health services. Benefit payments subject to family	Catastrophic plan: proposed HEW Office of Health Care.	Fiscal agents for outpatient plan, could administer inpatient	Office of Health Care within HEW	Replace Medicare and Medicaid.	Inpatient plan: general revenues and payroll premiums based on family income with federal subsidies for low-income	None at this time.	Jan. 1, 1973	By regulations issued by the Secretary.	Senate Finance Committee	Encourages the development of HMOs. Establishes grants and loans to students and medical schools to stimulate en-

"National Health Insurance Partnership Act of 1971"	Voluntary	NHISA. Two day deductible, 25% coinsurance per year for hospital, \$100 deductible, 25% coinsurance for all other benefits up to \$50,000. FHIP coinsurance and deductible based on income, applicable in varying degrees to 30 days hospital and physician services. Also, emergency, outpatient physician services, well baby and maternity care.	Private carriers and HMOs	Underwrite NHISA, option to drop HMOs, could be fiscal agent for FHIP	FHIP under Secretary of HEW.	Replace Medicaid to blind, disabled, aged, foster children	NHISA - employer/employee payroll deductions. FHIP by Federal Government and premiums scaled to income. FHIP cost \$1.2 billion in new Federal money. Byrnes under certain conditions, Federal subsidy for employers who employ 10 or fewer persons.	Administration	July 1, 1973	Retain present system. HMO payment on capitation basis.	Senate Finance, House Ways and Means Committees.	Encourage participation of HMOs.
"National Family Health Protection Act"	Compulsory Minimum benefits	In and outpatient hospital, ECF, medical and physician services, home health. Pays up to 120 days for hospital and ECF. 80% for next 120 days, 50% for next 125 days, then 50% of cost that exceeds 2% of a family's adjusted gross income in a benefit year. Pays first \$5 for physician home and office visits up to \$50 per year. Fee schedule for surgery.	Private carriers and pool for high medical risks.	Underwrite program.	Secretary of HEW.	Replace Medicaid and Medicare.	5% surcharge on personal income. Cost \$4 billion in new money.	None at this time.	Jan. 1, 1972	No change for physicians and hospital except fee schedule for surgery based on relative values.	House Ways and Means Committee	Secretary would issue health protection certificates which would be redeemed by carriers.
"Comprehensive Health Care Act of 1971"	Compulsory minimum medical and dental benefits.	To be phased in, in three stages to be virtually comprehensive for all by Dec. 31, 1978. State health plan for poor and near poor phased in by Dec. 31, 1976. Maximum amount of coinsurance and deductibles subject to adjusted income.	Private carriers and public pools	Remain the same with carriers participating in state pools for poor and near poor	Executive Health Planning Council and State Health Planning Council	Replace Medicaid, expand Medicare to include everyone over 65 and all persons now getting Social Security benefits.	Employer/employee contributions with employer paying 75% by July 1, 1974, aged ineligible now for Medicare Part A. A \$700 tax deduction for all permitted health insurance. Pools funded by state, federal and health insurance contributions. No estimate on cost.	None at this time.	Phased in, in three stages by Dec. 31, 1978.	State councils establish prospective rates for medical institutions, set rates for medical services including physicalian fees, and avoid duplication of federal and state medical funds.	House Ways and Means Committee.	Grants and loans to increase health manpower and facilities promote outpatient centers, authorize comprehensive health planning. Use existing major military hospitals to train new doctors and dentists.

CATASTROPHIC ILLNESS BILLS

"National Catastrophic Illness Protection Act of 1971"	Voluntary	Any services defined as medical care under Federal income tax law. Benefits effective after annual deductible determined by a family's income and size. No deductible for low-income persons.	Private carriers	Underwrite program.	State would design and establish plan under regulations issued by HEW	Retain Medicaid, would not pay for services covered by this program.	Premiums to insurers, with federal reinsurance for ex-carriers. Reinsurance would be paid by participating carriers. No estimate on cost.	None at this time.	Not specified	Retain present system.	Senate Finance and House Ways and Means Committee.	No provisions setting standards for providers of service.
"Extra Care"	Compulsory	Any services defined as medical care under federal income tax law. Provided through second program for all others. For poor, no deductibles or coinsurance. For others, deductible would be larger of \$5,000 for all under 65 or 25% of gross annual income after that, 90% of cost covered.	For poor, private carriers. For others, federally administered catastrophic program.	Underwrite basic and catastrophic coverage for poor and basic coverage for all others.	HEW through states.	Replace Medicaid, no specific reference to Medicare.	For poor, federal government would pay 85% of cost of basic premiums, states to pay balance and all catastrophic. For others: tax on wages, self employment income and other personal income. No estimate on cost.	None at this time.	Jan. 1, 1972	Program for poor: retain present system. Catastrophic Program same as under Medicare.	House Ways and Means Committee.	If a state does not participate, the federal government would pay all costs, then recover those costs by withholding federal funds otherwise payable to the states.
"Catastrophic Health Insurance Program"	Persons under 65 insured or entitled under Social Security, and their families. State and local governmental employees could be covered under special arrangements.	Same as Medicare with a 60 day deductible and coinsurance of 25% of Medicare deductible for hospital and medical expenses subject to 20% coinsurance after first \$2,000.	Private carriers as administrative agents	Fiscal agents	HEW through Medicaid, state agency setting quality standards.	Retains Medicaid, would not pay for services covered by this program.	Payroll taxes reaching 4% maximum of first \$9,000 in 1980. HEW cost estimate: \$2.5 billion for first year of operation.	None at this time.	Jan. 1, 1972	Same as under Medicare.	Senate Finance Committee.	Present Medicare control standards would apply.

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New Malpractice Rates

The annual report of our Committee on Medical Defense and Insurance to the 1971 House of Delegates described activity during the past year regarding our Professional Liability Insurance Program. Several major issues involving the insurance company's attitude required special attention.

A very important issue was the demand for another substantial rate increase of 48.5 per cent for this year. We would not accept this increase because it was not justified from material and statistics reviewed by our Committee. We informed the company, through the Britton Agency, that it should submit its requested increase to the New Jersey Department of Insurance and after final action by that department, we would again consider the matter.

The New Jersey Department of Insurance, after detailed actuarial analysis of submitted material and personal discussions with insurance company officials, rejected the requested increase in rates. Immediately prior to our 1971 convention, the company informed the Britton Agency that the lowest increase which could be acceptable to the company would be 40 per cent. In our opinion losses and experience in New Jersey did not justify this increase. We then informed the company that we would accept a 10 per cent increase as a maximum, and we directed the Britton Agency to contact other insurance carriers so we could accurately evaluate our position.

After contact with several companies, agreement was reached with the Federal Insurance Company managed by Chubb & Son, Inc., Short Hills, New Jersey, to provide coverage for new policies and all renewal policies on 1 November. The Chubb Companies are as large as our current company. The Federal Insurance Company has the highest possible ratings for financial strength and policyholder service in Best's Insurance Guide. The new company will continue our present program

with all loss control features. We agreed to accept a 10 per cent increase in rates because of the impact of inflation on professional liability losses.

The Committee has learned that Chubb & Son, Inc. has the finest reputation in all areas through the insurance, legal, and business professions, as well as with the New Jersey Department of Insurance. We are most fortunate to have this company to serve our members.

Employers Insurance Company, in accordance with the terms of outstanding policies, is obligated to protect all insured physicians for claims arising from acts during an insured policy period. All future reports, problems or questions, should be reported to the Britton Agency which will refer proper matters to the company.

Renewal policies with the new company have been prepared by the Britton Agency and were mailed to all insured members during September.

Medical Women's Association

The New Jersey Medical Women's Association operates a placement bureau for women physicians. Full-time and part-time positions are available. Call or write to Dr. Anna Haroutunian for possibilities. Her number is (201) 279-6213, and she may be addressed at 50 Belgrade Street, Clifton 07013.

Associate membership in NJMWA is available to interns and residents in all specialties. Medical students are welcome to attend the scientific meetings. For membership information, write to Dr. Sally Gill Keswani, 176 Mt. Pleasant Avenue, Livingston. telephone: (201) 994-1515.

The President of the Association, Myra Zinke, M.D., a Holmdel internist, is President-elect of the Monmouth County Medical Society.

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Each blue tablet contains:

Nicotinic Acid	100 mg
Niacinamide	75 mg
Ascorbic Acid	150 mg
Thiamine HCl (B-1)	25 mg
Riboflavin (B-2)	2 mg
Pyridoxine HCl (B-6)	10 mg

DOSE: 1 to 5 tablets daily

AVAILABLE: Bottles of 100, 500, 1000

NOT TIMED

LIPO-NICIN[®]/250mg.

Each yellow tablet contains:

Nicotinic Acid	250 mg
Niacinamide	75 mg
Ascorbic Acid	150 mg
Thiamine HCl (B-1)	25 mg
Riboflavin (B-2)	2 mg
Pyridoxine HCl (B-6)	10 mg

DOSE: 1 to 3 tablets daily

AVAILABLE: Bottles of 100, 500, 1000

GRADUAL RELEASE

TIMED RELEASE 6 to 8 HOURS

LIPO-NICIN[®]/300mg.

Each capsule contains:

Nicotinic Acid	300 mg
Vitamin C (Ascorbic Acid)	150 mg
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Vitamin B2 (Riboflavin)	2 mg
Pyridoxine HCl (B-6)	10 mg

DOSE: 1 to 2 capsules daily

AVAILABLE: Bottle of 100, 1000

In a special base so prepared that the active ingredients are released over a period of 6 to 8 hours

SIDE EFFECTS: Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid. **REFERENCES:** 1. Parsons, W.B., Jr. — Interview Med. Trib. Nov. 28-29, 1964. 2. Cohen, D., JAMA, Aug. 6, 1960, Vol. 173, No. 14, P. 1563.

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206th Annual Meeting
The Medical Society of New Jersey
May 6-9, 1972
Haddon Hall, Atlantic City

Program Outline

Friday, May 5, 1972

4:00 p.m. — Board of Trustees

Saturday, May 6, 1972

9:30 a.m. — Registration Opens
11:00 a.m. — Golden Merit Award Ceremony followed
by reception for GMA recipients and
their families
12:00 noon — Exhibits Open
2:00 p.m. — House of Delegates
3:00 p.m. — Reference Committees ("A", "B", "D",
"G", and Const. and Bylaws)
5:00 p.m. — Nominating Committee
7:30 p.m. — Reception-Buffer-Dinner
8:00 p.m. — Officers' Dinner

Sunday, May 7, 1972

8:30 a.m. — Registration Opens
9:00 a.m. — Exhibits Open
9:00 a.m. — Scientific Sessions
10:00 a.m. — Reference Committees ("C", "E", "F",
and "H")
1:00 p.m. — Scientific Sessions
3:30 p.m. — House of Delegates (election)
Addresses of President and President-Elect
6:30 p.m. — Inaugural Reception
8:00 p.m. — Inaugural Dinner

Monday, May 8, 1972

9:00 a.m. — Registration and Exhibits Open
9:00 a.m. — Scientific Sessions
1:00 p.m. — Scientific Sessions
3:15 p.m. — House of Delegates
5:00 p.m. — Exhibits Close
8:00 p.m. — Annual Dinner-Dance

Tuesday, May 9, 1972

9:00 a.m. — Registration Opens
9:00 a.m. — House of Delegates
12:00 noon — Registration Closes
1:00 p.m. — House of Delegates Adjourns sine die
8:00 p.m. — Board of Trustees

The Scientific Exhibits — —
206th Annual Meeting

The following information is pertinent to the scientific exhibit display at the 206th Annual Meeting of this Society, May 6 to 9, 1972. Those interested in participating may use the application form on page 951. (Please complete both sides.) Remove the page from *The Journal* and mail directly to Arthur Bernstein, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Policy—It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey, in instances where a pharmaceutical company has aided in the production of an exhibit—either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints or articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

Space assigned will be drapery booth consisting of a backwall and two sidewalls. Each booth is 6 feet deep. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a drapery booth.

Please indicate on the application if a sign is incorporated with your exhibit. If so, one will *not* be ordered.

If at all possible, a photograph of the exhibit should accompany the application. If a photograph is not available, a drawing will suffice.

Application for space in the Scientific Exhibit must be submitted no later than January 1, 1972, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit, to Arthur Bernstein, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 901, Trenton, 08605.

1. *Time*: The exhibits will open officially at 12 noon, Saturday, May 6, and close at 5 p.m., Monday, May 8. On the intervening day the hours are 9 a.m. to 5 p.m.

2. *Installation and Dismantling*: Installation of exhibits may begin at 3 p.m., Friday, May 5, and all exhibits must be in place by 11 a.m., Saturday, May 6. Exhibits must remain intact until 5 p.m., Monday, May 8, and should be removed from the exhibit hall not later than 12 noon, Tuesday, May 9.

3. *Cost*: The Society provides free of charge such space exhibitor may require, including booth with shelf, printed sign (*if requested*), and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, *including electrical connections*.

4. *Sponsorship*: All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space*: No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles*: Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising*: No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations*: All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures*: Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent*. The exhibitor must supply his own screen, projector, and operator.

10. *Liability*: It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorses nor assumes any responsibility for the contents of such exhibit.

11. *Awards*: Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission*: Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of the exhibitors will be deeply appreciated.

THE MEDICAL SOCIETY OF NEW JERSEY

206th Annual Meeting

HADDON HALL

ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 6-8, 1972

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use typewriter, or print, please)

1. TITLE (Generic names only):

Full Name and Degree of Exhibitor(s)

City State

Institution (if desired) City

Aided by commercial or pharmaceutical company

Exhibit constructed by:

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

3. Is the exhibit free-standing or self-contained?

4. SIGN required: SIGN not required:

5. Will backwall and dividers be required? (see sketch on reverse side):

6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15', depth 6'.

Desired inside clear backwall (8 to 15 feet) Minimum inside clear backwall

7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application.

8. Has this exhibit been shown in whole or part at any other scientific meeting?

If so, when? and where?

The undersigned agrees to abide by the regulations listed.

Name

Address

Date:

Return application to Arthur Bernstein, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey,
P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

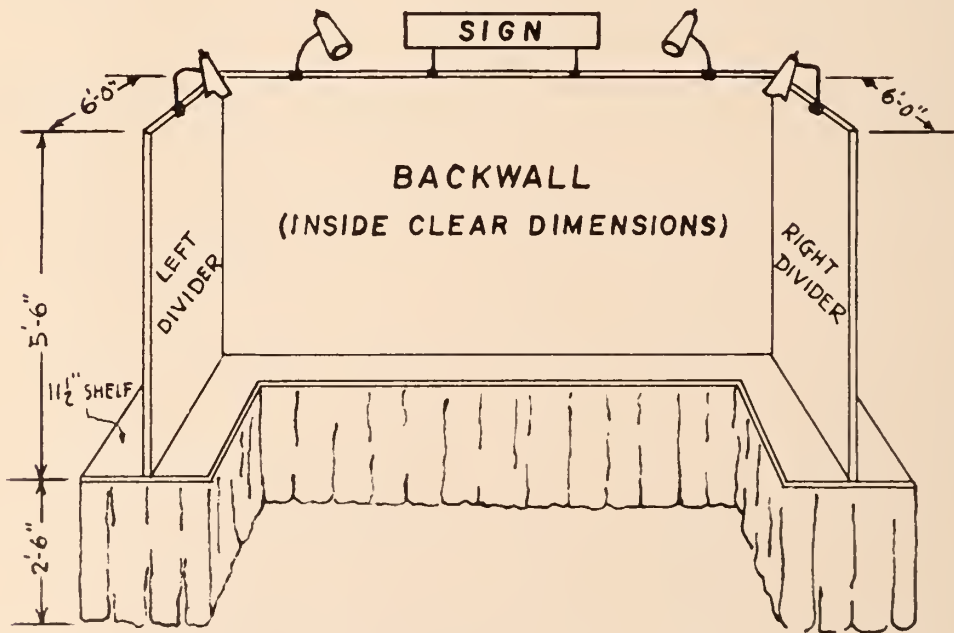
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:

	left divider		backwall		right divider	
Shelving	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
Overhead lights	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no

If your exhibit will not require backwall, or left or right dividers, please advise.

If a sign is incorporated within your exhibit, please advise, and one will not be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORMS

LETTER TO THE JOURNAL

Denial of Medicare Payments

September 21, 1971

Dear Editor:

My experiences with Medicare-B operations seem to suggest that policy changes, restrictions, and requirements upon physicians are making it progressively more difficult to obtain payment at fees previously adjudged proper by the Medicare agent. Thus, during the past month, payment was refused to me upon a claim for medical services to an aged lady totalling about \$170, because the claim

had not reached the agent within a specified time-limit after rendition of service.

I had, upon two occasions shortly after completion of my service, sent a Medicare-B claim form with attached itemized statement to the patient, asking her (or her daughter for her) to fill in her part and forward the claim for payment. In a letter to the agent, I indicated that it was impossible for me to compel promptness by a patient, and hence that it was an injustice to penalize me for a patient's failure. This has brought no response to date.

Other doctors must have had a similar experience. Perhaps you will agree that a change in policy is indicated in the premise, since aged and infirm patients are necessarily inept in the handling of such matters.

(Signed) Albert G. Hulett, M.D.

ANNOUNCEMENTS

Hypnosis Workshop

The New Jersey Society of Clinical Hypnosis will hold a basic workshop on November 12, 13, and 14 at the Holiday Inn in Parsippany, New Jersey. Small group instruction will be emphasized. Participation is restricted to doctors of medicine, dentists, and psychologists. For information, call Habiba A. Koblenzer, M.D., 193 Tooker Avenue, Springfield, New Jersey 07081.

Medical Aspects of Sports

The 13th National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association, will be held in New Orleans, at the Jung Hotel, on November 28, 1971. The Conference is on the first day of the Clinical Convention of the American Medical Association. Included will be discussion sections relating to drugs in sports, protection of the lower extremities, electrolyte and thermal balance, innovations in sports medicine through state medical societies, team physi-

cian relationships, crucial health perspectives, and a medical focus on athletics.

The Conference is open to key non-medical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Clinical Application of Basic Sciences

The "Clinical Application of Basic Sciences" series offered by the Burlington County Memorial Hospital has scheduled the following programs for December:

December 2 Interservice seminar
December 9 Suspected Testicular Neoplasm
December 16 Urolithiasis
December 30 Arthritic Hip

The American Academy of General Practice gives 1½ credits per session. Meetings are

held in the T. J. Summey Building of the Hospital and start promptly at 3:30 p.m. Please contact the Department of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly, for further information.

Soft Tumor Seminar

The New Jersey Society of Pathologists announces its annual seminar for December 4, 1971, in the auditorium of the Rutgers Medical College, CMDNJ, in New Brunswick. The colloquium starts at 1:30 P.M. The moderator, Saul Kay, M.D., Professor of Surgical Pathology at the Medical School of Virginia, will preside over a session on the general subject of "Tumor and Tumor-like Lesions of the Soft Parts." Chairman of the seminar committee is Hugh Luddecke, M.D. of Morristown. President of the Society is William V. McDonnell, M.D. of Camden. Supporting slides and protocols will be distributed to members of the society. Non-members who intend to come to the seminar may obtain study slides by sending \$16 to Dr. Luddecke at the Morristown Memorial Hospital, Morristown, New Jersey, 07960. For further information write to Dr. Hugh Luddecke at the Morristown address.

Rhinoplasty Workshop

A rhinoplasty workshop will be held in Toronto from February 6 to February 11, 1972. It is sponsored by the American Academy of Facial Plastic and Reconstructive Surgery. The course will include didactic lectures. Color television will be used to include live and tape productions of surgical technics. Topics include patient selection, analysis, photography, anesthesia, dorsum management, tip surgery, osteotomies, septal surgery, post operative care, grafts and implants, nasal fractures, profile plasty, and mentoplasty and

complications. The course is designed for those not necessarily expert in the field of rhinoplasty, and for residents. Registration fee is \$300, residents \$150. For details write to Mrs. Caroline Flynn, Division of Post Graduate Medicine, University of Toronto, Toronto, Ontario, Canada.

Advanced Rhinoplasty

A course in advanced rhinoplasty is announced for February 27 to March 3, 1972. This will be held at Baylor University College of Medicine, Houston, Texas. It is sponsored by the American Academy of Facial Plastic and Reconstructive Surgery. This workshop is for experienced surgeons who already perform this procedure but seek additional and more exhaustive instruction at advanced level. Priority is given to surgeons actively engaged in teaching. Registration fee is \$500. For details, write to Dr. William K. Wright, 508 Hermann Professional Building, Texas Medical Center, Houston, Texas 77025.

Soft Tissue Surgery

From January 23 to January 29, 1972, a program on soft tissue surgery will be offered at the Mercy Hospital in Pittsburgh. It is sponsored by the American Academy of Facial Plastic and Reconstructive Surgery. The workshop will review the fundamentals of soft tissue surgery in the region of the head and neck. Illustrated lectures, television tapes, and movies form the basic didactic material. The program includes operative demonstrations and laboratory exercises. Participants will be encouraged to present problem cases for discussion by the faculty. Registration fee is \$400 (reduction for residents and military personnel available). For more details, write to: John T. Dickinson, M.D., G-2 M. D. Building, 1501 Locust Street, Pittsburgh, Pennsylvania 15219.

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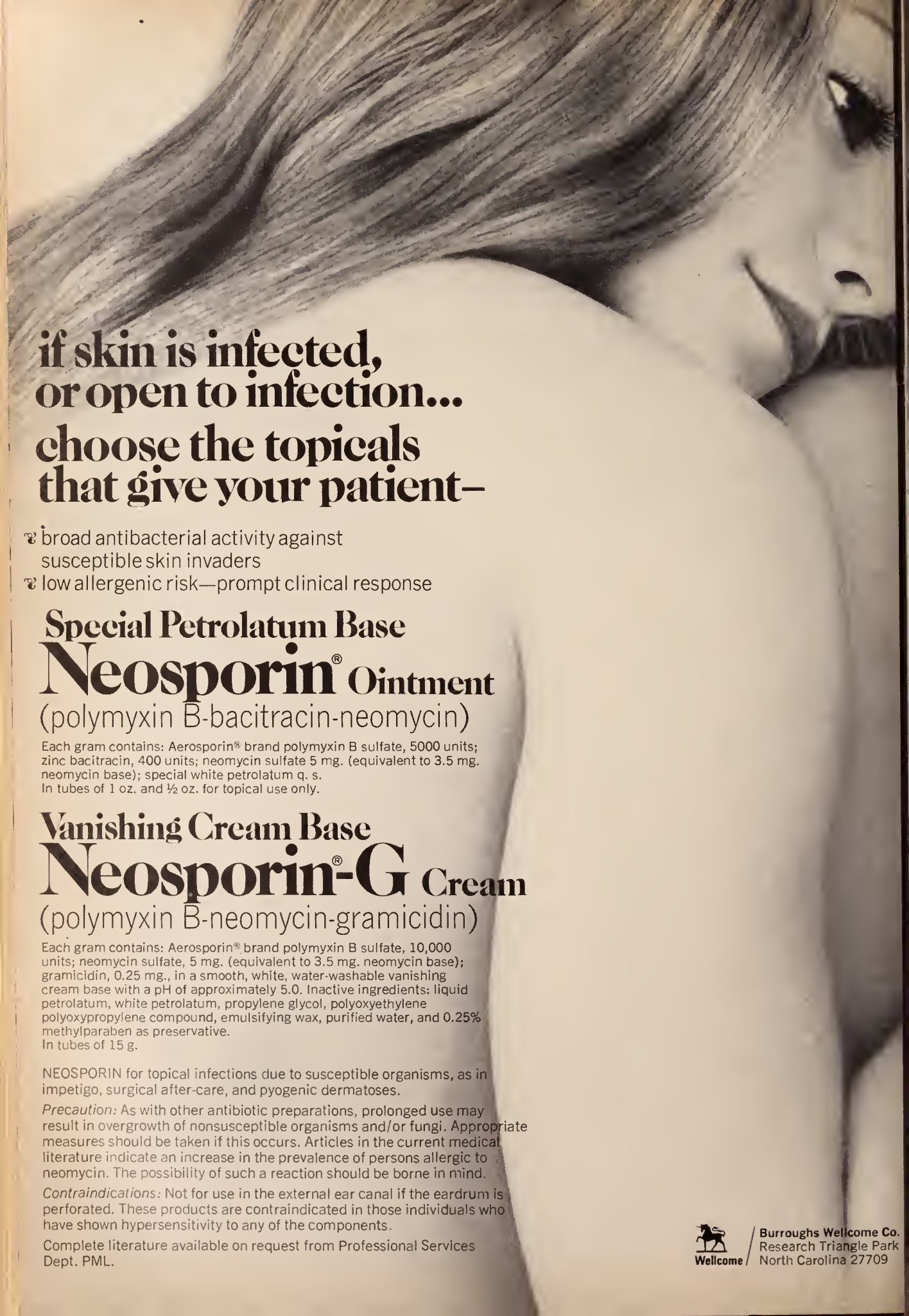
In treating hypermotility associated with functional lower G-I disorders are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent antispasmodic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of hypermotility, making it a highly effective agent in functional bowel distress, as well as in spastic and irritable colon. Robinul Forte also exerts a more selective action on the gastrointestinal tract. If the patient has a "one tract mind" concerning his lower G-I symptoms, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital—warning: may be habit forming).

Robinul® 2mg. Forte (glycopyrrolate)

INDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with acute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic pancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure syndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital may be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient glaucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 1 to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Blurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic drugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one tablet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum required to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

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Each gram contains: Aerosporin[®] brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.
In tubes of 1 oz. and ½ oz. for topical use only.

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Neosporin[®]-G Cream
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Each gram contains: Aerosporin[®] brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.
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NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.



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MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

November

- 10 Academy of Medicine of New Jersey
Saint Michael's Medical Center,
Newark
Psychiatry Symposium
- 10 St. Clare's and Dover General Hospitals
Leukemia and Chemotherapy
- 10 New Jersey Dental Association
Semi-Annual Session
- 10 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Chronic Renal Disease and Dialysis
- 10 Academy of Medicine of New Jersey
and Academy of General Practice
Hoffmann-La Roche, Nutley
Alcoholism
- 10 Academy of Medicine of New Jersey
Columbus Hospital, Newark
Newer Concepts of Hepatitis
- 10 Beth Israel Medical Center
Newark
Physiology of Renal Failure
- 10 Bergen Pines County Hospital
Paramus
ACP Meeting
- 11 Burlington County Memorial Hospital
Mount Holly
Crushing Injuries of the Chest
- 15 Academy of Medicine of New Jersey
Valley Hospital, Ridgewood
Difficult Diabetic Patient
- 17 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Pharmacology of Diuretics, Indications and Use

- 17 Beth Israel Medical Center
Newark
Physiology of Small Intestines
- 17 Bergen Pines County Hospital
Paramus
Clinical Aspects of Jaundice
- 18 Academy of Medicine of New Jersey
Jewish Hospital, Jersey City
Coronary Artery Disease
- 18 Burlington County Memorial Hospital
Mount Holly
Peritoneal Dialysis in the Community Hospital
- 24 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Electrolyte Imbalance
- 24 St. Clare's and Dover General Hospitals
Lymphomas
- 24 Academy of Medicine of New Jersey
Bloomfield
Allergy Section Meeting
- 24 Beth Israel Medical Center
Newark
Modern Virology
- 24 Bergen Pines County Hospital
Paramus
Paroxysmal Tachycardias

December

- 1 Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Urology, Including Prostatic Disease
- 1 Academy of Medicine of New Jersey
Saint Francis Hospital, Trenton
Proper Use of Antibiotics
- 1 Bergen Pines County Hospital
Paramus
CPC Meeting

- | | | | |
|-----|--|-----------------|---|
| 2-3 | Saint Barnabas Medical Center
Livingston
Gynecological Endoscopy | 1972
January | |
| 2 | Burlington County Memorial Hospital
Interservice Seminar | 5 | Bergen Pines County Hospital
Paramus
Megaloblastic Anemias |
| 8 | St. Clare's and Dover General Hospitals
Arteriograms and Lymphangiograms | 6 | Burlington County Memorial Hospital
Mount Holly
Viral Hepatitis: A Reappraisal of Mild Hypertension |
| 8 | Academy of Medicine of New Jersey
Saint Michael's Medical Center,
Newark
Urinary Tract Infections | 11 | Academy of Medicine of New Jersey
Bloomfield
Sectional Meeting: Dermatology |
| 8 | Academy of Medicine of New Jersey
Bergen Pines Hospital
Paramus
Pacemaker; Electrode and Vascular Surgery | 12 | Bergen Pines County Hospital
Paramus
Coronary Artery Disease |
| 9 | Burlington County Memorial Hospital
Mount Holly
The Management of Suspected Testicular Neoplasm | 13 | Academy of Medicine of New Jersey
Carriage Trade, East Orange
Venereal Disease Today |
| 11 | Academy of Medicine of New Jersey
Bloomfield
Section on Dermatology | 13 | Burlington County Memorial Hospital
Mount Holly
Current Concepts of Cardiomyopathy |
| 15 | Bergen Pines County Hospital
Paramus
Asbestosis | 19 | Academy of Medicine of New Jersey
College of Medicine and Dentistry at
Newark
Advances in Radiotherapy |
| 16 | Burlington County Memorial Hospital
Mount Holly
Medical and Surgical Management of Urolithiasis | 19 | Bergen Pines County Hospital
Paramus
Clinical Prospects of Prostaglandins |
| 17 | Academy of Medicine of New Jersey
Hudson County Meadowview Hospital
Secaucus
Venereal Disease Today | 20 | Academy of Medicine of New Jersey
Fairlawn Memorial Hospital
Saddlebrook
Diagnosis and Treatment of Shock |
| 22 | Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
Chronic Renal Disease and Dialysis | 20 | Burlington County Memorial Hospital
Mount Holly
Current Trends in the Therapy of Mild Hypertension |
| 22 | Bergen Pines County Hospital
Paramus
Abdominal Aortic Aneurysms | 26 | St. Clare's and Dover General Hospitals
Fluid and Electrolyte Balance |
| 22 | St. Clare's and Dover General Hospitals
Metastatic Disease of the Breast | 26 | Bergen Pines County Hospital
Paramus
Parkinson's Disease |
| 30 | Burlington County Memorial Hospital
Mount Holly
Evaluation and Management of the Arthritic Hip | 27 | Academy of Medicine of New Jersey
Jewish Hospital, Jersey City
Renal Failure |
| | | 27 | Burlington County Memorial Hospital
Mount Holly
Orthostatic Hypotension |

February

- 2 **Bergen Pines County Hospital**
Paramus
CPC Meeting
- 3 **Burlington County Memorial Hospital**
Mount Holly
Problems Related to Antidiuretic Hormones
- 9 **St. Clare's and Dover General Hospitals**
Renal Failure
- 9 **Bergen Pines County Hospital**
Paramus
Infectious Diseases I
- 9 **Academy of Medicine of New Jersey**
Columbus Hospital, Newark
Proper Use of Antibiotics
- 10 **Burlington County Memorial Hospital**
Mount Holly
Neurological Complications of Visceral Carcinoma
- 16 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Newer Concepts of Hepatitis
- 16 **Bergen Pines County Hospital**
Paramus
Infectious Diseases II
- 17 **Burlington County Memorial Hospital**
Mount Holly
Full Time and Voluntary Staff—The Interface
- 23 **St. Clare's and Dover General Hospitals**
Auto-immune Aspects plus Transplantation
- 23 **Bergen Pines County Hospital**
Paramus
Infectious Diseases III
- 24 **Burlington County Memorial Hospital**
Mount Holly
Newer Approaches to Community Health

March

- 1 **Bergen Pines County Hospital**
Paramus
Interstitial Lung Diseases
- 2 **Burlington County Memorial Hospital**
Mount Holly
Sterilization and Therapeutic Abortion

- 6 **Academy of Medicine of New Jersey**
Valley Hospital, Ridgewood
Diagnosis and Treatment of Shock
- 8 **St. Clare's and Dover General Hospitals**
Renal Vascular Hypertension; Malignant Hypertension
- 9 **Burlington County Memorial Hospital**
Mount Holly
Family Life Problems in Medicine
- 16 **Burlington County Memorial Hospital**
Mount Holly
Geriatric Psychiatry
- 22 **St. Clare's and Dover General Hospitals**
Secondary Nephropathies
- 23 **Burlington County Memorial Hospital**
Mount Holly
Alcohol: The Unglamorous Addiction
- 30 **Burlington County Memorial Hospital**
Mount Holly
Descent into Hell

April

- 6 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar
- 10 **Academy of Medicine of New Jersey**
Saint Francis Health Center
Jersey City
Proper Use of Antibiotics
- 12 **Academy of Medicine of New Jersey**
Veterans Administration Hospital, East Orange
Dental Symposium: Implantology
- 13 **Burlington County Memorial Hospital**
Mount Holly
Thermography
- 19 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Leukemia and Lymphoma
- 20 **Burlington County Memorial Hospital**
Mount Holly
Radiography in Evaluation of Gastrointestinal Diseases
- 27 **Burlington County Memorial Hospital**
Mount Holly
Diseases of the Esophagus

OBITUARIES

Dr. David Keyser

Born in 1908, David Keyser, M.D. died on August 20, 1971, at the age of 63. He was a well-known family doctor in southern New Jersey, a 1934 graduate of Hahnemann. During World War II, he was a captain in the medical corps of the Army of the United States. He was on the staff at the West Jersey Hospital and active in committee work for our Camden County Component Society.

Dr. Louis C. Lange

A well-known Hudson County surgeon, Louis C. Lange, M.D., died on August 17, 1971, at the age of 85. He was a 1908 Bellevue graduate and was, for many years, on the surgical service of the Christ Hospital in Jersey City. Dr. Lange was a Fellow of the American College of Surgeons, and a member of the New Jersey Society of Surgeons and the Academy of Medicine of New Jersey.

Dr. James V. Lyons

At the age of 74, James V. Lyons, M.D., died on August 13, 1971. He was a well-known gynecologist and obstetrician on the staff of St. Mary's Hospital in Orange, before his retirement to Rumson some years ago. Dr. Lyons was in the class of 1921 at Fordham. He was a Fellow of the American College of Surgeons and of the American College of Obstetrics and Gynecology.

Dr. Joseph T. McGuire

Word has just been received of the death, in October 1970, of Joseph T. McGuire, M.D., a member of our Bergen County Medical Society. Dr. McGuire's field was industrial medicine, and for years he was medical director at the Mahwah plant of the Ford Motor Company. He was a 1933 graduate of Long Island (Downstate) Medical College. Born

in 1906, Dr. McGuire was 64 at the time of his death.

Dr. Louis Meltzer

Long active in family practice, Louis Meltzer, M.D., who had been born in Europe in 1898, died in Bayonne on August 26, 1971. He came to this country in childhood and was graduated in 1923 at the Medical School of the University of Michigan. Dr. Meltzer was on the staff at the Bayonne Hospital.

Dr. Eugene J. Politowicz

A very active member of the Camden County Medical Society, Eugene J. Politowicz, M.D., died on August 2, 1971 at the untimely age of 36. He was a general practitioner affiliated with the West Jersey Hospital in Camden. Dr. Politowicz was a member of the class of 1961 at the College of Medicine and Dentistry of New Jersey at the time when that was still part of Seton Hall University.

Dr. Franklin W. Rice

On August 4, 1971, Franklin W. Rice, M.D., died at the age of 77. He was an alumnus of Columbia University's College of Physicians and Surgeons, where he received his medical degree in 1917. He was, for many decades, identified with Morris County and was an active member of that County Medical Society. Dr. Rice was a general surgeon affiliated with All Souls Hospital in Morristown, and was a Fellow of the International College of Surgeons.

Dr. William R. Tilton

William R. Tilton, M.D., was in the class of 1917 at Jefferson Medical College. After a decade of general practice in Summit, he joined the medical department of the Prudential Insurance Company which he served for 32 years until his retirement in 1955. He was active in committee work for the American Public Health Association. Dr. Tilton moved to Madison after his retirement and died there on August 5, 1971, at the age of 80.

BOOK REVIEWS

Intensive and Rehabilitative Respiratory Care.

Thomas L. Petty, M.D. Philadelphia, Lea & Febiger, 1971. Pp. 294. Illustrated. (\$9.75)

The care of the critically ill has engendered much discussion over the past few years. Policies of organization for "Critical Care Units" have been developed. The necessity of continuing education programs has been exemplified. The team approach has been stressed.

Most critically-ill patients require respiratory care. A common mode of death is respiratory failure. Yet many hospitals cannot render effective respiratory care because of lack of facilities or adequately trained staff. The need for arterial blood gas analysis and mechanical volume ventilators has long been recognized. Hospitals that cannot provide these services cannot provide adequate respiratory care.

Dr. Petty and his collaborators from the University of Colorado Medical Center have written a fine, simple, and practical approach to respiratory care. The management of many types of respiratory failure is clearly expounded. The methods are succinctly explained. A valuable section of the book concerns the organization of a "Respiratory Care Service." The importance of the team approach is stressed, as well as the necessity for basic knowledge and technical ability.

All "Critical Care Units" should have a copy of this book available for immediate reference. Improved patient care and patient survival will result. We cannot ask for more.

William R. Thompson, M.D.

Review of Medical Physiology (Edition 5). William F. Ganong, M.D., Los Altos, California, Lange Publishing Company, 1971. Pp. 573. Illustrated. (Soft-back \$8.50)

In a sense, the basis of all medical practice is an understanding of physiology. When a patient is sick there is something wrong with his physiology and it is the doctor's job to discover what it is. However, the actual study of medical physiology has been a much neglected branch of medical teaching for many decades. The present text is the fifth edition of a paperback which has been available since 1961. The popularity of the book is perhaps the best evidence of its usefulness. No specific area of coverage will satisfy the specialist but that, of course, is not the purpose of the book. The material for example on the physiology of nerve and muscle cells will not satisfy the neurophysiologist and so with the material on the dynamics of the heartbeat. However, it is all here in sufficient detail to meet the needs of the general practitioner as well as the medical student. The book is further improved by tables of atomic weights, conversion tables, ranges of normal values and blood plasma and serum, and numerous diagrams and tabulations.

Victor Huberman, M.D.

Synopsis of Pediatrics (3rd Edition). James G. Hughes, M.D. St. Louis, Mosby, 1971. Pp. 1141. Illustrations 88. (\$14.50)

With this third edition, Dr. Hughes has brought his book up to date. He reports on the rapid changes in the care of children, since his last edition four years ago. The size of the book is the same as in 1967. Its contents remain an "ocean of pearls" for the student, the family physician, the pediatrician, the pediatric nurse, and for any others who care for children. The twenty-eight brief chapters cover just about every phase of pediatric study by as many eminent members of the specialty.

This reviewer recommends the text for its brevity, wisdom, and pragmatic approach to the fundamentals of pediatrics, and for its review of basic science and applications to clinical practice. The busy physician who can carefully review the twenty-eight chapters should feel as well prepared and knowledgeable as any expert in answering parents' pediatric questions.

Of particular interest is the chapter on respiratory diseases, which covers the most common causes of illness in infancy and early childhood, and brings the child most often to the physician. It is a truly superior review of the subject.

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Handbook of Psychiatry (Edition 2). Edited by Philip Solomon, M.D. and Vernon D. Patch, M.D., Los Altos, California, Lange Publishing Company, 1971. Pp. 648. (\$7.50)

Two years ago Solomon and Patch edited a new type of handbook of psychiatry. One of the new features was that much of the material was written by junior practitioners rather than by the senior men in the field. This proved to be an interesting innovation and there has been enough demand for the Solomon-Patch handbook to justify this second edition. The book is well organized as a practical review of the problems of the specialty. It is focused largely on the needs of the psychiatric resident and the general practitioner but it is also useful for social workers, clergymen, psychologists, and even psychiatric aides. The text starts with a review of doctor-patient relationships and goes on to an explanation of the relationships between the mind and the brain and discusses psychiatric examination techniques. The text covers topics in genetics, epidemiology, mental hospital administration, the use of statistics, and the various psychiatric illnesses considered separately. There is a separate section on psychiatric treatment with an unique division on the handling of psychiatric emergencies. Also included is a chapter on drug therapy, on electroshock, group therapy, and behavior therapy.

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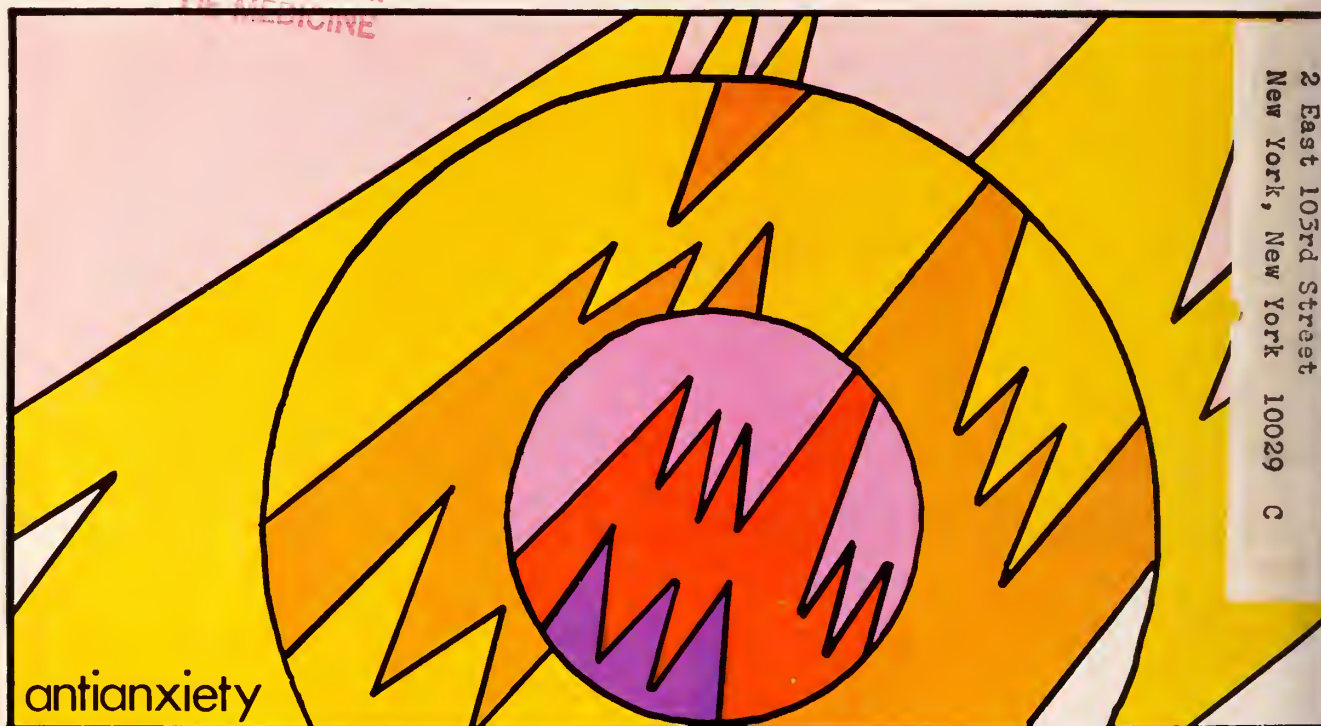
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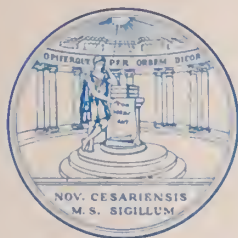
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JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

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DECEMBER 1971
VOL. 68, NO. 12

THE MEDICAL SOCIETY OF NEW JERSEY

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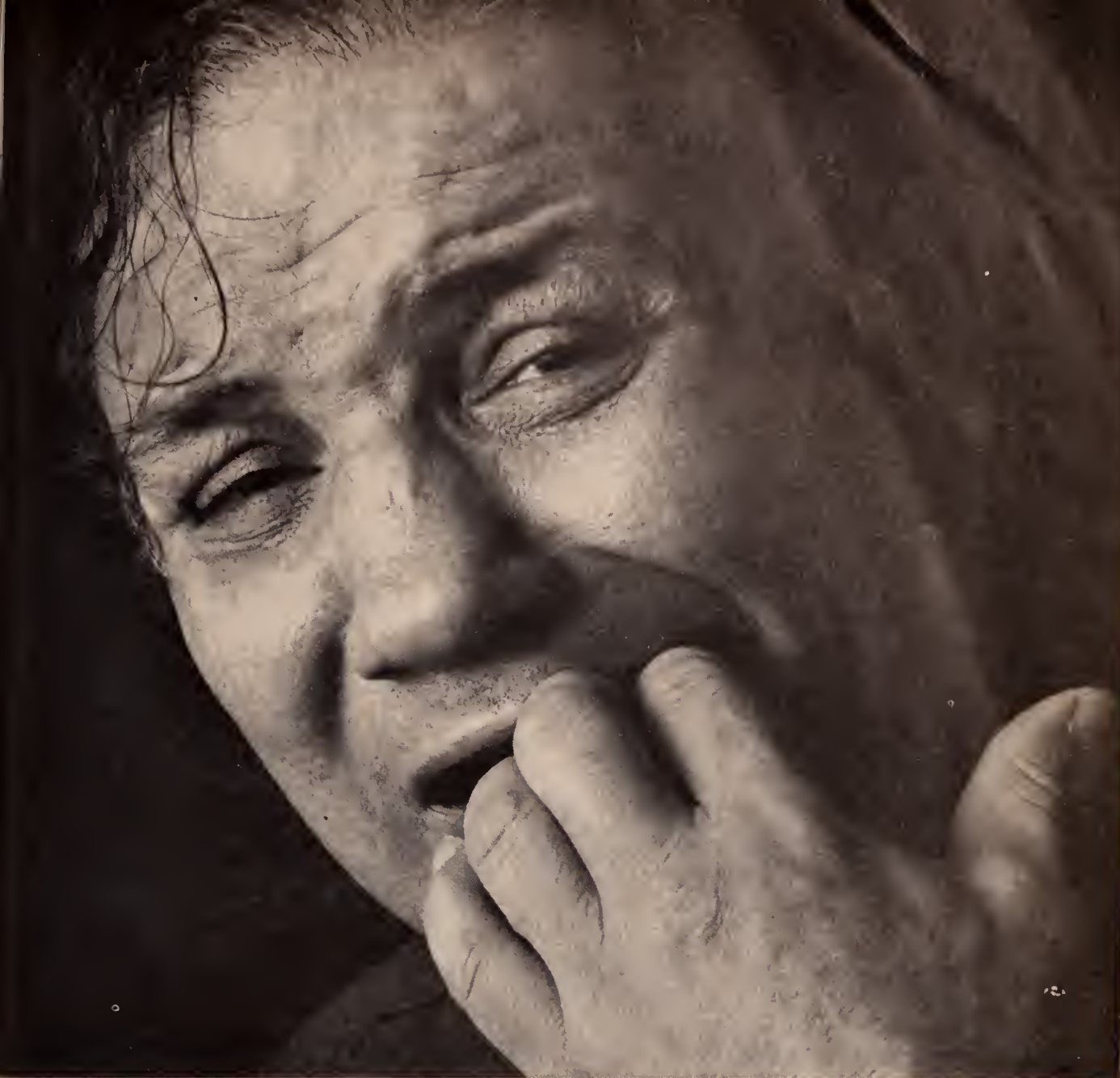
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EDITORIALS

Curing Is Easier Than Healing

Etymologically, *cure* and *care* were the same word. The clergyman, whom the French call a *curé* (and the British a *curate*), was vested with the cure (care) of souls. Over the centuries, however, the word has shifted in meaning. Now, instead of curing a person, we cure a disease. Indeed, the adjective "cured" is seldom used on hospital discharge sheets. We prefer to say "recovered" as more modest and more accurate. You can cure a pneumonia by medication. Do you cure the person? As a better example, you can cure a gangrenous foot or hand by amputation. Is the person cured?

The word *heal* has a different background. It is analogous to *whole*. The words *hale* and *healthy* have the same root. Today we speak of "healing" in the sense of restoring a person to a sense of well-being, making him "whole" again. Thus, when we amputate a hand, we cure the gangrene. But when the patient makes a good adjustment with a prosthetic hand, he is "healed."

Curing in the modern world is easier than healing. To cure the organ you need technical knowledge of what can be done to excise the diseased tissue. But to heal the individual you need art and compassion as well as knowledge of a technic. Many of the critics of our system of distributing medical care concentrate on the curing technics, offering to "vend" such methods. It is interesting that many of the critics of our system of distributing medical care are people who have not been involved in it. Those physicians who don't like our system have come largely from academic circles or large practice groups, where medical care is dispensed more in units of treating diseases than in the more subtle effort to try to heal the whole man.

Yes, healing is harder than curing for it involves the establishment of a rapport, the surrender of some of our time, and a devotion to the often-thankless ministry of listening. But in these days of computers, curing (in the direct mechanical sense of applying a learned technic) can be done programmatically. It may be that it won't need a physician at all. Punch the symptoms on to one card and the treatment program comes out the other.

Responsibility of Physician in Control of Venereal Disease

Our complacency on venereal disease has received a rude shock from public health authorities who state that new cases of syphilis are increasing at an alarming rate and that gonorrhea is now pandemic throughout the country.

It is time for countershock. The general public has a part to play in increasing awareness of the problem and in educational efforts to combat the root causes; promiscuity, ignorance, and laissez faire. Physicians man a special and important sector of the battlefield. It is a shameful statistic that while physicians practicing privately treat 80 per cent of the venereal disease, they report to their local health departments only one out of every eight cases of syphilis and one out of nine cases of gonorrhea. The passers of these diseases must be traced down and checked by treatment. The law is perfectly clear on this. It is our one certain method of control. We urge 100 per cent reporting, in the knowledge that this information is confidential and will be used in such diplomatic fashion that no harmful repercussions can arise.

Physicians know their role and must bear down hard in fulfilling it. The era of complacency is over.

Editorial from the July 15, 1971 issue of *New York State Journal of Medicine*.

ORIGINAL ARTICLES

Presented here is a practical monograph on plastic repair of the hand in congenital deformities.

Congenital Hand Deformities*

Jerome Spivack, M.D./Irvington

The best classification of congenital limb malformations that I have found is that of Swanson, Barsky, and Entin.⁴ They have tried to classify these malformations on the basis of embryological failures. Their classification is as follows:

I. Failure of differentiation of parts.

- (a) Shoulder—undescended scapula, absence of pectoral muscles, etc.
- (b) Arm—synostosis of the elbow.
- (c) Forearm—synostosis of proximal ulna and radius.
- (d) Hand.
 - 1. Syndactyly—from simple skin bridging to fusion of parts.
 - 2. Contracture—secondary to failure of differentiation of muscle, ligaments, and capsular structures—from simple trigger thumb to flexion contracture of the little finger (campodactyly) to severe arthrogryposis.
 - 3. Lateral deviation or displacement due to asymmetrical abnormalities of the digits (clinodactyly).

II. Arrest of development of parts.

- (a) Transverse—congenital amputation from aplasia to amelia.
- (b) Intermediate—classical phocomelia.
- (c) Longitudinal.
 - 1. Radial—absence of radius, partial absence to hypoplasia of the thumb, etc.
 - 2. Central—the various types of cleft hand or lobster claw.

- 3. Ulnar—deficiency of 4th and 5th fingers with carpal bones and ulna.

III. Duplications—from polydactyly to twinning or mirror hand.

IV. Overgrowth—digital gigantism.

- V. Congenital Circular Constriction Band Syndrome—presents with constriction rings, fetal amputation, and areas of focal necrosis.

VI. Generalized Skeletal Defects—the hand deformity may be only one manifestation of an over-all syndrome.

Syndactyly

Syndactyly may be called complete when the webbing extends to the end of the fingers and incomplete when it does not. It is simple when only soft tissue joins the fingers and complicated if bony or cartilaginous tissue joins the fingers. In over one half the cases only the third and fourth fingers are involved. Many different methods of repair^{5, 11} have been suggested. The web may be reconstructed by either a dorsal or volar rectangular flap or triangular flap or by two interdigitated dorsal and volar triangular flaps. The lateral sides of the fingers may be covered by using the volar or dorsal skin as a laterally based flap to cover one finger. The other finger can be covered by full thickness skin graft. The incisions on the fingers are zig-zagged and the creases are darted to decrease the likelihood of flexion contracture.

Another method is to zig-zag the incisions on the fingers and approximate the tips of the volar and dorsal flaps about the fingers. This produces two or three diamond-shaped areas on the side of each finger which can be

*Read before the section on Plastic and Reconstructive Surgery, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1971.

grafted using either a full thickness or split thickness graft.

In all cases, the excess subcutaneous tissue should be trimmed away to give normal shape to the fingers, to prevent tension in skin closure and to decrease the amount of skin grafting. One should never release both sides of the same finger at the *same time*.

When there is a bony or cartilaginous bridging this must be separated. These areas should be covered by local flaps rather than skin grafts. Prior planning is very important to determine the location of these flaps. Flatt,⁷ feels that one should not hesitate to separate longitudinally fused bones in a small child. This can be done easily with a scalpel and growth will not be disturbed.

Many of these patients have additional anomalies involving other parts of the body and also the fingers involved by the webbing.^{6, 7, 10, 11, 12} In some cases the syndactyly is only a minor part of the over-all deformity. Epstein and Bennett¹² have noted that in those cases brachydactylia was also present in the syndactylous hand.

The most severe form of syndactyly is that found in Apert's syndrome or acrocephalosyndactyly. These patients have many cranial and facial deformities in addition to their hand problems. There is usually syndactyly of all the fingers and frequently the thumb is also involved.^{11, 13, 14} In early life they have some motion in the interphalangeal joints but by age four these joints are stiff.¹⁴ The thumb is very short and is deviated radially at the metacarpalphalangeal joint. At times the syndactylous digits are fused into a mass of bones and joints. Any attempt to separate them would be more debilitating than leaving them to function as a composite unit.¹¹

Treatment recommended by Hoover, Flatt, and Weiss,¹⁴ is release of the thumb and little finger before one year of age. About six months later the long finger is removed and the skin from it is used to cover the index and ring fingers. Emmett,¹¹ recommends am-

putation in some cases of these very complex cases of syndactyly. These patients need further surgery later, such as osteotomies to place the fingers in flexion and to correct the radically deviated thumb tip.¹⁴

Contracture

Congenital thumb in the palm or thumb contracture in the newborn has been treated by splinting the thumb. The problem is due to a failure of normal development of the structures that provide extension for the thumb and the fingers at the metacarpal phalangeal joints. There is also a volar soft-tissue contracture.^{8, 15} Crawford, Horton, and Adamson,¹⁵ have treated this by a combination of soft tissue releases with grafting and tendon transfers to the central slips of the thumb and finger extensors as needed.

Camptodactyly or congenital flexion contracture is usually an isolated deformity of the fifth finger seen in children in which there is a gradual progressive contracture of the proximal interphalangeal joint. It tends to become worse during periods of rapid growth. Occasionally all of the fingers are involved with those on the ulnar side being more severely affected. Smith and Kaplan¹⁶ advocate section of the flexor digitorum superficialis of the involved finger. This method was indicated when there was evidence of a mobile proximal interphalangeal joint. Others have advocated tendon lengthening, splinting, and release of skin and capsular contractures with coverage by skin grafts and flaps.

Lateral Deviation

Clinodactyly may be caused by a wedge-shaped piece of bone which may be supernumerary or may be the normal phalanx. Treatment should consist of manipulation and splinting initially. If this is not effective and if the deformity is causing functional and esthetic deformity, it can be corrected by wedge osteotomy.⁸

Arrest of Development of Parts

Entin,¹⁷ has had considerable experience in the reconstruction of congenital aplasia of

the phalanges. In these cases one is more concerned about function than esthetics. The patient must be provided with supple skin, with normal sensation, with efficient pinch and grasp, and with the ability to place the hand in useful positions. Treatment includes separation of parts by phalangization and deepening of web spaces, shifting of bony elements, ablation of parts, pollicization, lengthening of digital components by shifting of skin and bone grafting and construction of digits with pedicle flaps, bone grafts and toe transfers. As the deformities become more severe, the type of reconstructive procedures become more complex.

Deformities of the radial side of the hand and forearm may vary from a minor defect seen only on x-ray to complete absence of all the radial structures. In the typical radial dysplasia, the carpus lacks radial support and the hand becomes deviated, the amount depending on the degree of dysplasia. The affected limb is usually shorter than the normal limb.¹⁸ Interphalangeal joint motion is limited because the extrinsic tendon excursion is decreased by their curved course, because a considerable amount of force is dissipated displacing the unstable joint¹⁹ and because of poor wrist extension due to frequent absence of the wrist extensors.²⁰

Presently, most authorities recommend splinting of the hand in a corrected position,¹⁸ soft tissue release as necessary,¹⁹ and centralization of the hand over the wrist and K wire fixation.²⁰ This fixation abolishes the waste of power of the extrinsic muscles of the digits and encourages maximum movement of the fingers. Stabilization of the wrist without good elbow function prevents the hand from touching the face or body.

Pardini,¹⁸ noted that even with centralization and wrist fusion there was some degree of radial angulation at the site of the ulnar-carpal implantation. Bora, Nicholson, and Checma,¹⁹ treated their series by centralization with removal of the lunate and capitate and placement of the ulna into this slot at six to twelve months of age. A K wire fixes

the wrist and is removed six weeks later. The position is then maintained by splints. Six to twelve months later the superficialis tendons to the third and fourth fingers are transferred proximally and then in an ulnar and dorsal direction to the second and third metacarpal. They report 72 per cent satisfactory results in these patients. The tendon transfers have helped correct the problems of wrist subluxation and progressive ulnar bowing which were noted after wrist centralization alone due to the overpowering strength of the wrist flexors.

In carrying out the soft tissue releases, surgeons have noted that the median nerve is a superficial structure that may be the one structure at the end of the operation which is still preventing complete correction of the radial deviation.²⁰

Going along with the radial dysplasia are variable deformities of the thumb. In Pardini's series of thirty-nine cases,¹⁸ the thumb was present in twelve, absent in nineteen and hypoplastic in eight. Edgerton *et al.*,²¹ noted that if the thumb was present, its metacarpal was absent and its phalanges were small and cartilaginous. It was attached more distally and its base was often constricted by an annular band. The extensor tendons were commonly absent and the thenar intrinsic muscles were frequently absent or fibrotic.

The elbow and wrist must be taken care of before the thumb can be reconstructed. Edgerton, Synder, and Webb²¹ noted that if the thumb was sufficiently large and stable it was left and procedures were planned to improve it. If it was small with the first metacarpal missing, it may be amputated and reconstructed using pedicle flaps, toe joint, or complete toe transfers and neurovascular island flaps. The best method was transfer of a finger for the thumb. They prefer to begin the surgery about age two. They outline many of the anomalies of the arteries, veins, and nerves that may be found during the operative procedure.

Rybka and Paletta²² distinguish between the totally absent or dangling thumb which is more frequent and requires pollicization for reconstruction and the hypoplastic thumb found at the end of a relatively normal radius that may be suitable for bone graft pollicization. Harrison²³ has treated his cases in a similar fashion. He had one particularly severe case with shoulder, elbow, and wrist involvement. The standard pollicization would never have been used effectively so he turned the little finger to make a thumb on the ulnar side of the hand with good results.

Central

Barsky,²⁴ has had considerable experience with the cleft hand or lobster claw hand. The typical pattern presents with a deep web, with absence of varying portions of the third finger dividing the hand into a radial and ulnar component. This type benefits from attempts to narrow the cleft and reconstruct the web space with a local flap. The atypical pattern is more severe and the central three digits are absent, it is usually unilateral and the feet are normal. The thumb and little finger are present but may be attenuated. In the latter type, it is best not to try to bring the segments together as this may destroy useful function. At times it is necessary to remove small remnants and abnormal bones which keep the two pincers apart. Rotational osteotomy may be necessary.

Duplications

Duplications or polydactyly may vary from a very small nubbin located on the ulnar side of the fifth finger to complete reduplication of the thumb.²⁶ Radial polydactylism is twice as frequent as ulnar polydactyly⁸ but reduplications on the ulnar side are usually bilateral.²⁵ Central reduplication is the least common representing 6 to 8 per cent of the cases.

Polydactyly of the fifth finger is usually the simplest to manage with an aplastic stub with rudimentary cartilage. Occasionally there may be an articular facet on the ulnar side

for the extra digit.⁸ This must be removed surgically.

Central polydactyly is usually associated with syndactyly. The metacarpal may be enlarged, distorted, bifurcated distally, or fused. Joint distortion may complicate the repair.

Radial polydactyly is the most common variety and ranges from simple broadness of the distal phalanx to complete reduplication with triphalangism. Barsky⁸ recommended a wedge resection of the bifid tip and a reefing of the capsule when there is any deviation of the remaining phalanx.

Wassel²⁶ presented several interesting findings among a group of cases of polydactyly of the thumb followed over many years. The cases were divided into seven different groups from the simplest to the most complex. He found many cases of radial or ulnar deviation at the interphalangeal or metacarpalphalangeal joints and also a loss of flexion or a hyperextension at these respective joints. Other problems found were loss of tip and palmar pinch, a decrease in tip and palmar power, a decreased opposition and occasionally a contracted thumb web space. He recommends surgery before school age.²⁶ If one waited too long the supernumerary component displaced the normal component in a radial or ulnar direction. At this stage ablation of the accessory portion is not enough and one must either reconstruct the collateral ligaments, do an osteotomy or fuse the joint. Surgical excision of the entire supernumerary component in the very young may damage the epiphysis, resulting in premature closure and a shortened smaller thumb. He recommended surgery at age three in which the duplicated portion is removed but the bifurcated proximal articular surface is left for a later time when growth is completed. In the triphalangeal reduplication, the best results were obtained by removing this segment.

At times, surgery on supernumerary digits should be postponed, if there is a possibility that the bony elements may be needed as a bone graft in other parts of the hand.³

Overgrowth

Enlargement of the fingers and hands may be caused by hemangiomas, lipomas, and nerve tumors. Macroductyly is a form of enlargement in which all the structures of the involved digits show an increase in size. Barsky²⁷ finds two varieties. The first is the static type which is usually seen at birth and the further increase in size is proportionate with growth of the other parts. In the second type, there is a faster growth of the involved fingers than the normal growth pattern. Frequently there is an overgrowth of fatty tissues in the palm, dorsum of the hand, and forearm.

A common factor which has been found in almost all cases of macroductyly²⁷ has been an enlargement of the nerves to the involved parts.³⁰ Some have reported that the excessive finger growth ceased when the digital nerve was totally excised but Tsuge,²⁸ prefers to remove individual small branches.

In the very young child stapling the epiphysis,²⁷ removal of the epiphyseal plate, or fusion of the bones may be done to slow down the growth rate.²⁸ In older children and adults with a marked enlargement,²⁷ staged procedures are done with excision of portions of the middle and digital phalanges with arthrodesis of the surfaces.²⁸

Bulges of excess tissue can be excised at staged procedures. The digit can be thinned by removal of hypertrophic nerve branches and adipose tissue from each side of the finger by staged procedures three months apart. Tsuge²⁸ has developed a procedure to move the nail proximally on a dorsal flap while shortening the finger. Excess bulges are removed later. Barsky²⁷ stated that some of the progressive types may be complicated by syndactyly. Amputation may be necessary in some of these but fatty overgrowth may take place proximal to the amputation site.

Congenital Circular Constriction Band Syndrome

These cases present four different findings³¹ which until recently were not clearly understood.³⁵ Patterson³² has presented a comprehensive paper on the subject. Included in this group are: (1) simple ring constriction; (2) ring-constriction accompanied by deformity of the distal part with or without lymphedema; (3) ring-constriction accompanied by fusion of the distal parts (acrosyndactyly); and (4) intrauterine amputation. These deformities may be present in any combination in a single case.

In acrosyndactyly there is a fusion of the distal portions of the digits while the proximal region and the web spaces are unaffected. The treatment of these cases is similar to that of simple syndactyly except that one must dissect out the epithelial lined tracts.

The constriction rings may be mild in which case no treatment is necessary. They may be moderate in degree creating mainly a cosmetic problem which can be resolved by performing multiple Z-plasties about one half of the circumference of the digit or limb. In the severe variety surgery is imperative³¹ because of the lymphedema³² and again Z-plasties in stages are performed.³⁵

Summary

The classification of congenital limb malformations was discussed and attention called to one particular classification based on embryologic failure which provided an excellent guide for indexing these anomalies. Many of the commoner and a few of the rarer deformities were discussed, especially regarding treatment, optimal age of surgery, type of surgical procedures advocated in recent years, and possible problems encountered.

A bibliographic listing of 35 citations is available upon request.

40 Union Avenue

Because an undetermined number of copies of the November 1971 issue were bound with pages 883-886 missing, they are here reprinted as pages 979-982.

EDITORIALS

The Rising Tide of Self-Medication

As doctors, we have always frowned on self-medication by untutored laymen. The reasons are obvious. And since the development of television, the situation has become more distressing, with many TV commercials now showing the inside story of how Peregrin's Panacea Pills slide gently down the trachea into the spleen and, in technicolor, chase out the germs and the ulcers.

Yet, from time to time, medical people do say some kind words for self-medication. It has been suggested that there are fewer mishaps with harmless home medicines than with potent pharmaceuticals. It has been suggested that the rule of the market place applies and that the widespread popularity of non-prescription drugs must mean that they are doing something right. Most observers believe, however, that much of our country's orgy of self-medication is due to high pressure radio and television advertising. Some of it, let it be confessed, is due to the reluctance of some doctors to make calls on what sound like minor complaints. As a profession, we have to decide whether we should continue to oppose self-medication (and if so whether we should not, in support of our position, be more regularly and swiftly available) or whether we should encourage a wider use of the commercially advertised, over-the-counter, self-prescribed proprietaries. Or it may be that Gilbert Weil, the well-known New York attorney, was right when he said that people "have an instinct to medicate themselves" and that we would simply encourage "bootleg use of home remedies," if we continued to insist on the old-fashioned idea that only people who know something about pharmacology should decide which drugs ought to be poured into the human body.

More Than Two Million Dollars Paid

November is Life Month. This is the eleventh annual Life Month for The Medical Society of New Jersey Life Plan. More than 1,750 members currently participate in this Plan. During the past year, thirteen death claims were filed, bringing the total paid to \$2,115,000.

The Plan not only provides up to \$100,000 coverage for members, but a member's spouse, son or daughter, or employee can also participate in the program up to \$50,000 each. Each insured person, be he member, dependent, or employee, has an individual noncancelable life insurance policy at the extremely low group cost. It is not necessary for a member to be insured in order for his dependents or employees to participate in the program. The same liberal dividend structure applies to all policies issued under the Plan.

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Professional Corporations have found the program ideal for a corporate benefit plan with employee coverage available and complete assignment of ownership and beneficiaries to suit every need.

During November, members under 65 are invited to apply for up to ten \$10,000 units of term life insurance including what they already carry. All policies have double indemnity benefit and waiver of premium as well as a guaranteed conversion privilege without extra cost. Complete information is being sent to members by our administrator, E. and W. Blanksteen Agency, Inc.

Here is a highly practical method for treating bladder decompensation.

Bladder Decompensation in Cancer, Cardiac Disease, and Stroke

Willard M. Drake, M.D./Camden

Many patients suffering from cancer, cardiac disease, and stroke are being denied the benefits to be obtained from urethral catheter drainage.¹ It is the purpose of this paper to review the etiology, diagnosis, management, and complications of bladder decompensation, and describe a method of determining the return of compensation.

Fear of urinary tract infections and Gram-negative septicemias complicating urethral catheterization has dissuaded some physicians from the use of the urethral catheter. Actually, the normal urinary tract (properly managed) will withstand catheterization and free itself of infection, even though infection may follow a period of catheter drainage instituted for bladder decompensation.²⁻⁹ Intelligent care depends on the ability of the physician to arrive at the diagnosis of bladder decompensation, his knowledge of catheter care, and his ability to determine the presence of the return of the bladder to a state of compensation.

Bladder decompensation results from lesions of the nervous system secondary to sensory loss, motor loss, or destruction of the reflex center; iatrogenically, from central nervous system depressants, antihypertensives, relaxants, and local trauma; from inability to assume the natural position; and from primary urologic obstructive disease. Lesions of the nervous system may be primarily vascular, as

in stroke; malignant, either primary or secondary; degenerative, as in diabetes, pernicious anemia, and multiple sclerosis; inflammatory, as in meningitis, poliomyelitis, and transverse myelitis; or secondary to trauma, involving the brain, cord, or peripheral nerves. The trauma may be primary or secondary to surgery.

Medications likely to cause decompensation from central nervous system action are anesthetics, narcotics, sedatives, hypnotics, antihypertensives, and tranquilizers. These usually allow the bladder to overdistend before the sensory stimuli get strong enough for the brain to recognize. Of the sedatives, barbiturates are least apt to cause bladder distention as they as a group tend to be parasympathomimetic. Muscle relaxants include the ganglionic blockers, bronchodilators, antihistaminics, sympathomimetics, and antihypertensive drugs.

Trauma secondary to childbirth, anterior colporrhaphy, urethral instrumentation, and abdominal perineal resection of the colon may be sufficient to cause decompensation either by itself or in conjunction with the above-mentioned factors.

Primary urologic obstructive diseases capable of producing bladder decompensation include phimosis, meatal stenosis, urethral strictures and valves, prostatic hypertrophy, prostatic malignancy, prostatic abscess, and urethral stone. If present, these diseases must

be treated before compensation can ensue. The urologist's work, in large part, involves bladder decompensation of varying degrees and he has the most extensive experience in catheter care and bladder decompensation, and its complications.

Initial symptoms of decompensation consist of frequency, urgency, and difficulty of urination. Later symptoms are pain, overflow-incontinence, and complete retention. Physical evidence of a lower abdominal mass, suprapubic dullness to percussion, with or without palpable mass, indicate a distended bladder. Further evidence is a decrease in P.S.P. and elevation of BUN or creatinine and x-ray evidence of retention on the postvoiding film of the intravenous urogram.

Treatment

Gently pass a latex or silastic Foley type retention catheter, using the sterile technic. Administration of Demerol® by hypodermic 20 to 30 minutes prior will facilitate this. Decompression of the bladder should be instituted in cases of chronic distention. A specimen should be sent for smear, culture, and sensitivities, and the catheter connected to a closed drainage system. Catheter hygiene in the male consists of the application of antibiotic salve to the urethral catheter junction once or twice a day after cleansing. In the female use a pitcher douche once or twice a day, using Zephirin® solution, or acetic acid (one eighth of 1 per cent), or similar agent.

Bladder irrigations may not be needed unless infection, debris, or obstruction indicate. Sterile-gloved technic should be used with solutions varying with the condition. Acetic acid one eighth of 1 per cent is useful for Gram-negative and urea splitting infections. Commercially available buffered citric acid solutions may cut down encrustations. Commercially available antibiotic bladder irrigant is effective against most pathogens. Sterile saline and enzyme solutions are useful in breaking up mucus and blood clot. Silver nitrate solution is hemostyptic.

Antispasmodics should be given initially and continued as needed; either ganglionic blockers such as atropine or antihistaminics or a narcotic. If these do not control spasms, an opium and belladonna suppository usually will. An antibiotic is ordered initially for five days usually a sulfa drug or a Nitrofurantoin®, to be changed if the clinical course or sensitivities suggest a different drug is needed.

The catheter or tubing should be secured to the clothing or bedding to prevent pulling of the retaining bag into the urethra, and in the male to keep the penis in the anatomic position to prevent pressure necrosis and abscess formation at the penoscrotal junction. The catheter should be changed at the earliest indication of poor drainage or sanding.

An alternative treatment, consisting of placement of a silicone rubber or polyethylene catheter by suprapubic puncture, for short term drainage until resumption of function, is being used successfully, especially in gynecologic procedures and in some pediatric applications.¹⁰⁻¹² Direction for use and proper care come with the commercially available kit. This avoids some of the tendency for infection and the urethral discomfort of the standard urethral catheter.

Infection will probably occur if the catheter is worn for more than four days. Infection will usually respond to the indicated antibiotic and be eradicated following removal of the catheter, when and if the bladder returns to compensation.

Spasm usually responds to the drugs listed. However, some patients (especially where nerve lesions of the upper cord or brain are present) find that the catheter stimulates reflex activity which will tax the best efforts of the urologist. Narcotics by hypodermic needle or opium and belladonna suppository or local bladder instillations of Pontocaine® may succeed in interrupting this. Pyelonephritis, bacteremia, and septic shock result from failure to treat infection and spasm. Calculous disease of the bladder or kidneys is a late complication if the suggested treatment

is poorly carried out. Periurethral abscess usually develops as a result of allowing the penis and catheter to fall between the thighs, producing pressure necrosis of the urethra at the penoscrotal junction. Treatment is best by prevention. Otherwise, suprapubic diversion and local drainage are necessary.

Compensation

1. An estimate of bladder compensation may be made at anytime but practically is deferred until the exciting cause has been treated and the patient has stabilized. The patient should be off heavy sedation and tranquilizers and be fairly mobile, that is, have bathroom privileges.

2. Physical examination should rule out an anatomic defect as obstructive prostatic disease which may require surgical correction.

3. An antibiotic should be begun the day before removal as determined by sensitivities and continued for three or more days as indicated. Antispasmodics should be discontinued.

4. By irrigation of the bladder with a bulb syringe, capacity, sensation of distention, and motor activity can be fairly accurately determined. A capacity of 350 to 450 cc., a sensation of desire to void at 250 cc., a fullness with more acute desire to void at 350 cc. or more are normal. Motor activity should cause urine to escape from catheter if held vertically under 30 centimeters of water pressure.

5. On the day of removal of the catheter the bladder should be filled with irrigating solution plus one syringe full of air, the catheter removed and patient allowed to void in a natural position. All the solution plus the air should come out. If no air comes out the catheter should be reinserted.

6. As an alternate to this, instill one ounce of 10 per cent Nitrofuracin® solution and remove the catheter; then have the patient record times and amounts of void. In either case the patient should be checked carefully for the next 48 hours to be sure voiding is of good quantity and there is no evidence of bladder distention by percussion or palpation.

7. Appropriate antibiotics as determined by sensitivity studies should be given as indicated, with follow-up for one to two months after catheter removal to be sure any infection is eradicated.

8. Patients with neurogenic or obstructive disease may require corrective surgery.

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The usually non-toxic methenamine mandelate can cause a fatal allergic reaction.

Hypersensitivity to Methenamine Mandelate

Julian I. Joseph, M.D./Wayne and Amil M. Joshi, M.D./Paramus*

An 80 year-old male was admitted to Bergen Pines County Hospital with right foot drop. He had had progressive weakness of the right leg for two months and right leg pain, with occasional numbness, for one month prior to admission. He had previously had pain in the thigh and in the back. He drank two glasses of wine daily, and he had been a smoker. He was well-nourished, oriented, and cooperative. Blood pressure was 180/80. His lungs revealed a few moist basilar rales and diminished breath sounds, with dullness at the bases. Neurologic examination revealed a marked weakness of the right foot. The right ankle jerk was diminished. Tendon reflexes generally were diminished. Sensation was intact. Hemoglobin was 5.4 grams; WBC 4200; 63 per cent segs; 30 per cent lymphs; 5 per cent eosins; 2 per cent monos; platelets adequate; ESR 50 mm per hour; and reticulocytes, 4.6 per cent. A single white blood count of 2,700 was recorded. Otherwise the leukocyte count ranged from 4,000 to 6,000.

A week after admission, the neurologic consultant noted that the patient was disoriented for time and place. He was unable to move his right foot. He showed weakness and wasting of muscles generally but most marked at the upper extremities. Impression at this time was deep peroneal nerve damage, polyradiculopathy; possible lower motor neuron disease. Urine culture showed 200,000 organisms per cubic centimeter. Sensitivity studies included methenamine mandelate.† The patient was given three units of packed cells. Methenam-

ine mandelate‡ was started a few days later. His course was afebrile.

On the 30th day after admission he was semicomatose and had a left hemiparesis. Ulcers were noted on the legs. The next day, a generalized rash developed over the body including the lower extremities. Twenty-four hours later the rash appeared exfoliative. The blood pressure on this day was 130/70 and then 102/76. Soon, his speech was slurred the left arm weak, and the patient confused. Twenty-four hours later he was dead.

Chemistries drawn on the day of death, showed a BUN of 114, sodium 145, chloride 121, potassium 5.4 and carbon dioxide 14. At autopsy, a diffuse erythema was present over the skin of the back, lower extremities, scrotum, and to a lesser extent the upper extremities. The back also contained deeper red macules. Lower extremities were ulcerative and partly scaling, and showed multiple fine macules or petechiae which were largely confluent. The anterior chest skin had fine brown pigmented areas. The upper extremities had a purpuric as well as a macular erythematous eruption. The liver weighed 1180 Grams and showed a finely nodular or granular cirrhotic pattern. The gallbladder was fibrotic, contracted, and contained multiple small yellow-green calculi. A moderate splenomegaly of 210 Grams was present. The kidneys were

*Professor Joseph is Associate Pathologist and Dr. Joshi is a resident in medicine at the Bergen Pines County Hospital in Paramus, from which this work comes.

†Mandelamine® is the Warner-Chilcott tradename for the brand of methenamine mandelate used in this case.

atrophic—right 65 Grams, left 75 Grams. They showed a fine granularity with a superimposed diffuse, nodular scarring. The lungs appeared full and somewhat firm; they weighed 1160 Grams in total. Two small recent infarcts were noted at the diaphragmatic pleura of the right lower and left lower lobes. Adhesions to the diaphragm were noted at the right pleura. The heart was of normal weight, but showed severe coronary atherosclerosis and calcification, with 80 per cent narrowing of the right main, left anterior descending, and left circumflex coronary arteries. No myocardial scarring or infarcts were noted grossly.

Lumbar vertebrae showed marked osteoarthritic changes, with bony spurs, widening of the vertebral bodies one and one half times, and narrowing of intervertebral spaces. The skull showed mild thickening of the parieto-occipital diploe. The cerebral arteries at the base of the brain showed moderate atherosclerosis. On sectioning the brain, a cystic zone of encephalomalacia was found in the right parieto-occipital white matter. Except for mild dilatation of the lateral ventricles, the brain was otherwise unremarkable.

Histologically, the heart showed slight focal interstitial fibrosis of the left ventricle, and mild focal interstitial myocarditis with eosinophils, lymphocytes, polymorphonuclear leucocytes, and occasional histiocytes. Section of coronary artery showed fibrinoid substance and leucocytic exudate with occasional eosinophils, superimposed on atheroma with fibrosis in the intima and adjacent media of the nearly occluded vessel. Lungs revealed focal interstitial pneumonitis, moderate emphysema and interstitial fibrosis, acute congestion and edema. Lower lobes showed organizing pulmonary infarcts with embolic occlusion of arteries in the region of the infarct. In the liver, we saw a granular cirrhosis with fine septa, moderate diffuse fatty change, and centrilobular congestion. An axillary lymph node had prominent eosinophils throughout the medulla. Peripheral

nerve of right lumbosacral plexus showed, within several adjacent nerve bundles, edema, chronic inflammation, and myelin swelling and degeneration. There was vascularization within the nerve bundle, and perineural fibrosis. The spleen had many eosinophils in the reticulum and on some malpighian corpuscles.

The skin revealed a moderately severe subacute inflammation in the dermis; many eosinophils were present. The epidermis showed prominent parakeratosis and focal areas of liquefaction. The brain revealed an organizing encephalomalacia of the right parieto-occipital region. Many pigmented macrophages and astrocytes were present. The vertebral marrow showed moderate hypercellularity and prominent clusters of eosinophils and eosinophilic myelocytes.

This patient entered the hospital with hemolytic anemia, borderline leucopenia, neuritis, and bilateral pleural effusion. The clinical signs suggested a disease process involving multiple organ systems.¹

During the patient's hospitalization he received methenamine mandelate† for a urinary tract infection due to *Klebsiella*. One intramuscular injection of vitamin B¹², 1,000 micrograms, was also given. No other drug preparations were administered. The general condition of the patient remained unchanged until a month after admission, when he was found semicomatose and had a left hemiparesis. A generalized skin rash appeared the following day and his neurologic status deteriorated.

What was the cause of death? What role did methenamine mandelate† play in the dramatic four day terminal episode? Autopsy showed severe coronary atherosclerosis with superimposed fibrinoid and eosinophilic exudate in the intima, but there was no myocardial infarction. The pulmonary infarcts were not large enough to cause the death. A small focus of weeks-old organizing encephalomalacia could not by itself account for the termi-

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nal episode. The granular cirrhosis was not associated with an appreciable necrosis. Signs of portal hypertension were minimal. It is difficult to implicate the liver in this patient's downhill course. Possibly the terminus was due to a combination of coronary and cerebral atherosclerosis, with the added effect of the coronary vasculitis.

Methenamine mandelate† appears to have caused a fulminant allergic reaction resulting in the patient's death. No other therapeutic agent could be implicated. This is a drug of extremely low toxicity. Nausea, epigastric distress, diarrhea, burning on urination, and urticaria have been noted. This drug can be used for long periods of time without adverse effect. Serious reactions are extremely rare.^{2,3,4} Although methenamine mandelate† appears to be implicated in this patient, it seems likely that somehow an underlying process or predilection was contributory.

Allergic reactions of a histamine type^{5,6} have been reported in the course of systemic lupus erythematosus, set off by drugs, such as penicillin, sulfa, tetracycline, and streptomycin—for example, Stevens-Johnson syndrome due to sulfa.^{1,7} These reactions are relatively frequent in the aged. Serum sickness is a hypersensitivity reaction of the immediate type, which histopathologically shows lesions very close to those of lupus. The allergic reaction manifested by the patient in this study shows a resemblance to both serum sickness and lupus erythematosus, but all of the diagnostic findings of lupus are not present. The case suggests the requirement for a more embracing definition of lupus-like states, and points to the need for understanding the mechan-

isms of this disease condition in relation to hypersensitivity reactions of the immediate type.

Summary

An eighty year-old male was admitted with weakness, hemolytic anemia, and leucopenia. His course was marked by a dramatic terminal allergic process while on methenamine mandelate† for a urinary tract infection.

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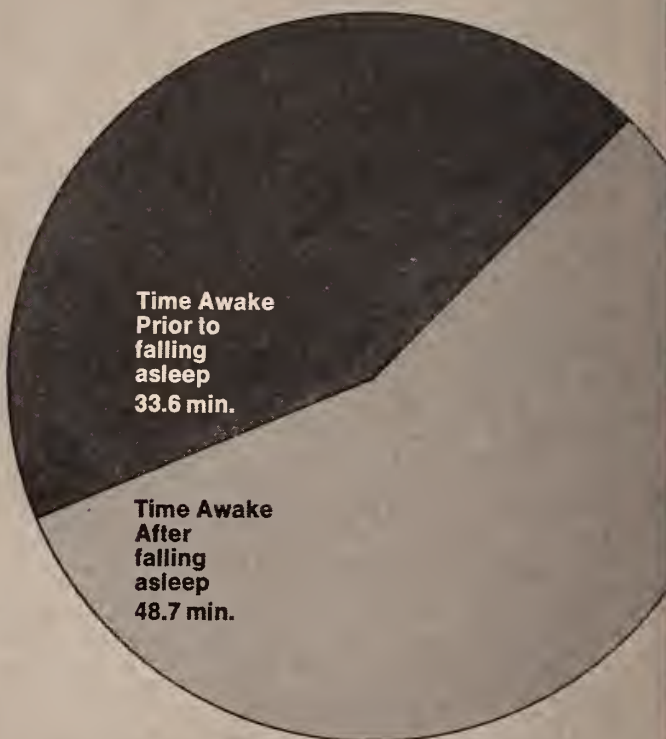
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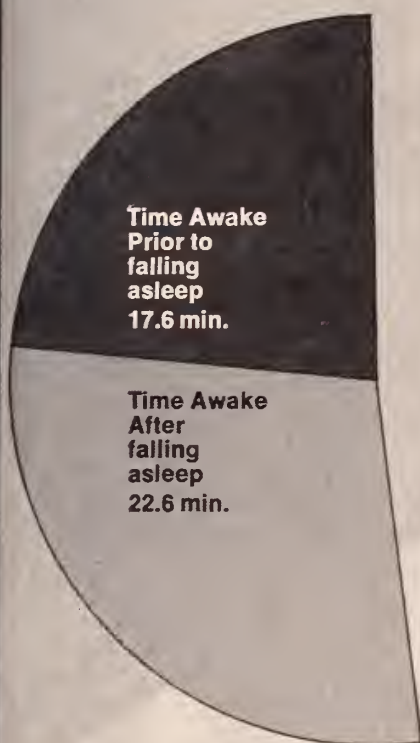
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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

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Any physician planning to establish, expand, or review an ICU will find this careful monograph a usable blueprint.

Observations on Intensive Care Units

James E. D. Gardam, M.D.* /Belleville

During the sixties, a major and dramatic advance in medical care was the development of the Intensive Care Unit in hospitals.¹ It became apparent that death due to electrical disturbances of the heart (resulting in lethal tachyarrhythmias) could be prevented. This depended upon close supervision of the patient, early recognition of arrhythmias, and swift treatment. All this could be facilitated by placing the patient, equipment, and trained personnel in a single area of the hospital. Three years ago Tansey, Nestler, and Minogue² presented a report on this development. My own report here is not concerned with clinical material since the literature is replete with this type of study. Rather, this paper is concerned with management aspects of the Intensive Care Unit (ICU).

An intensive care unit, to operate successfully, must be developed by the willing and continuous cooperation of the hospital trustees, administration, and medical staff. A unit is expensive to develop and to operate and affords no opportunities for savings. Changing developments in equipment and technics necessitate continuous expense. The concentration of acutely ill patients in a single location permits more efficient staffing of regular floors and more efficient, higher level of care to the less acutely ill who remain on general care floors.³

Construction of a unit, *de novo*, will require alteration of some type within a short period of years. This must be accepted and administrative officers must expect continued

expenditures in order to maintain the highest level of patient care. Furthermore, ICU's present new problems from day to day. Administrative officers and trustees must manifest active concern for the operation of a unit. In the years ahead, no hospital will be considered a first class installation without a functioning ICU. Trustees and administrators must oversee the development of these units which means keeping abreast of new data in the field. This concern should also have a permanent place on the agenda of a hospital patient-care committee made up of staff, administrators, and trustees.

The Unit in the Community Hospital

Historically, the Intensive Care Unit was developed primarily in teaching hospitals and still serves as a useful research tool. How about the usefulness of such units in the community hospital? Some clinical research presently does derive from the community hospital level. Even if this aspect of the ICU is eliminated, the unit still serves a major function for the community hospital. It leads to a higher level of patient care for the patient who requires such care.

The lessons learned at the university level can be extended to the community institution by utilizing the small, but previously trained and motivated, cadre of professional personnel which staff the units. It is probably safe to say that an institution without an intensive care unit in the next decade will not rank as a hospital.

*Attending in Medicine and formerly Director, Intensive Care Unit, Clara Maass Memorial Hospital, Belleville, New Jersey.

Physical Construction

Although we find no firm studies which define the size of combined intensive care and coronary care units, our review of institutions in the New Jersey area suggests a formula of five beds per hundred beds as the optimum for community hospitals. This differs from previous reports which suggest that one bed per seventy-five is adequate. The number recommended here encompasses all specialties. There is some semantic confusion here, too. Is it a surgical intensive care, medical intensive care, or coronary care unit? The problems faced by the community hospitals in developing units concern space, personnel, and expense. A reasonable solution is the development of the back-to-back combined unit wherever feasible. Coronary and medical intensive care beds when physically closely associated permit efficient utilization of available beds and trained personnel.⁴

Proximity to the surgical suite and recovery room is valuable. Proximity to the emergency room (in localities with a high incidence of trauma) would have proponents. Proximity to x-ray and laboratories in hospitals equipped for, and interested in, cardiac catheterizations could also prove valuable.

We have seen only one institution so constructed that all of the above are on a single floor. However, such construction occupies many square feet of land which is not usually available and produces some of its own problems. In general, let it be said that specific location should not be a bar to the development of a unit but that clear, easy, rapid access is the key. The installation of a single elevator could be far less expensive than land acquisitions or foundations for a building extension. Planning should include the greatest amount of working floor space possible. In emergencies there is never enough clear space.

Coronary care units require no bathrooms. The use of a commode often suffices. Patients able to use a bathroom should, presumably, be transferred to a regular floor. However, surgical patients may benefit from construc-

tion of bathrooms. It is necessary to include a suitable room for patients requiring isolation in a combined Intensive Care Unit. It would be appropriate for this type of room to have an attached bathroom primarily for the hand-washing of nursing personnel. Also provide adequate storage, locked, to permit self-sufficient operation through a week-end with a full census. Adequate staff facilities are needed, too. The staff room should be equipped for teaching with library facilities, bulletin boards, blackboards, and so on. This facilitates in-service education within the confines of the unit and permits personnel to be available for emergencies. The unit should be constructed with windows to permit awareness of time changes and better contact with reality. Visitor control is a constant problem. Facilities close to the unit are necessary to provide for the comfort of visitors. Also provide quiet, good color, appropriate temperature control, and safe, efficient movement of beds and equipment. Because of the need for constant revision, the fewer items of "built-in" equipment the better.

If choice is possible, beds should be placed so patients may be able to be viewed from a side or lateral position rather than from the distorted toe to head view. The absence of adequate working floor space should not preclude the initial development of a unit. The published description of a small unit in Anne Arundel (Maryland) County Hospital is recommended as an example of a small unit. We have seen a well-functioning two-bed unit and a unit which utilizes space on two floors in New Jersey community hospitals. Both units provide a level of care far in excess of the space available. It is better to have a small unit than no unit at all. All units are subject to change and administrators and trustees must accept this need. The greater the available space, the more functional the unit. However, trained personnel will adapt to limited space.

Equipment

There are probably more hours spent on equipment selection than any other problem

in the development of a unit. Unit planning commissions are deluged with electronic salesmen. Most of the time thus spent is wasted.

Initially, a unit can function adequately with a monitor for each bed, a defibrillator, and an electrocardiogram. As skills increase, sophisticated level additions can be made as they are found to be desirable. Selection of equipment by "old-line" firms is recommended and the maintenance service contract is perhaps the most important part of selection.

Once a firm has been selected and its service is found satisfactory, additions should be from the same firm. The proper grounding of compatible equipment is necessary to avoid "micro-shocks" which may increase morbidity and mortality from tachyarrhythmias. A consulting electronic engineer or physicist may be invaluable in promoting safety and assisting in filtering and conflicting claims made by electronic firms.

Ready-made crash carts are satisfactory for emergency room or floor use. A simple table in the unit with shoe bags attached can serve to keep all necessary equipment for resuscitation readily available.

A fixed headboard on the hospital bed interferes markedly with intubation under emergency circumstances. All headboards are removed from beds in our unit. Motorized beds should be grounded properly with detachable plates to permit interchange of beds.

Because heart block is less common than ventricular arrhythmias, it is imperative that a defibrillator be an initial piece of equipment. With the development of teams capable of utilizing transvenous pacing, pacemakers should be acquired. They should be stored in the unit under lock and key with appropriate inventory control and be available at all times.

The number and position of adequately grounded electrical outlets is one item never found in sufficient numbers and this item of "equipment" should not be limited. Recom-

mendations found in the literature suggest eight outlets per bed.

Nursing Personnel

The unit is operated by nurses. In the community hospital the hour-by-hour care of the critically ill patient will be rendered by the nursing personnel. Also, until such time as the intern and resident return to the community hospital, the primary defense in the definitive emergency treatment will be by the nursing personnel. It is the adequate number of motivated, trained, active nurses which actually constitutes the unit.

A review of prevailing practices suggests that nursing personnel for the unit should be selected with the active advice and consent of the medical director of the unit. This provides an opportunity to assess motivation, level of special education, and general acceptability to the demands of the unit. Often, nursing administrators are reluctant to cede any prerogative in this area and fail to recognize that cooperation will not diminish their authority or respect.

Active participation in the selection process by the Medical Director has distinct advantages. It establishes the role of the director in the operation of the unit. It permits an appraisal of the future educational needs of personnel. It provides an evaluation of motivation, stamina, and adaptability. No clearly defined profile of successful ICU nurses exists. We have found that nurses who are successful, however, are young, healthy, well motivated, and energetic to the point of exuberance. Sometimes they are not classed as academic successes in school but demonstrate early leadership, multiple interests, and *nursing* ability.

Training Programs

Training of nurses for units should begin in the nursing school. We have noted a marked change in the curriculum of diploma schools to meet the need for skilled unit personnel. Three factors are here involved. The most obvious is the demand for unit person-

nel. The second is the alertness of the young instructor who not only recognizes the need but is quick to urge curriculum changes as a reflection of the desire to be relevant to the needs of society. The third factor is the desire of the student to fulfill her ambition to perform active nursing. To the student, the unit is "where it's at!"

The pace, the action, the status of working in a unit appeals to the young girl. The young student does not fear electronic equipment—she has her own high-fi and tape deck—nor does she fear new procedures such as defibrillation since she has not known such treatment to be otherwise. Furthermore, the young student regards herself as a self-sufficient, equal, and an actively *participating* member of the health care team. These factors make the young graduate nurse an ideal candidate for selection for ICU staff.

The nursing school curriculum is in a state of flux. Emphasis on cardiac nursing, based on physiological and pathological principles, begins early. We have endeavored to introduce cardio-respiratory resuscitation into the early part of freshman year. This provides additional available trained personnel in the hospital setting. Student nurses *can* save lives. Early training also permits students to feel a sense of active participation in the care of patients—her training becomes relevant.

Cardiac arrhythmias are taught in the second year concurrently with the life history of atherosclerotic heart disease. It has been interesting and rewarding in our own institution to see the period of student experience in the unit increase from two weeks to six weeks. This permits a firm grasp of principles, assists the student in making her decision for future specialization, and allows for evaluation and recruitment of personnel prior to graduation.

We have observed two small problems in the education of student nurses toward ICU. One is the slow change over the years toward education of student nurses by nurses and the elimination of the teaching role of the staff

physician. Part of this has been due to abdication of this role by the physician himself. A partial reversal of this trend is suggested as a means to the enrichment of the students' educational process.

A second problem has been the reluctance of some instructors to permit students intellectually to invade what has been arbitrarily defined as the physician's domain. There has been a hesitant restraining attitude when students demonstrate a skill in electro-cardiographic interpretation, intubation, or defibrillation. It is anticipated that the march of events will overcome this reluctance but its demise should be encouraged by physicians.

Because of constant change in nursing technics as medical advances reach the community hospital level, education must be on a continuous basis. The four-week course provided in the past by Rutgers, Newark Beth Israel, Overlook, and other centers is ideal to train the graduate nurse. This high level theory and practice study is an intellectual challenge to the graduate nurse and also provides the self-assurance and security necessary to full performance. Courses like this should be provided for all unit nurses and it is recommended that the costs of the course (plus continuation of salary) be borne by the employer, the hospital. The rewards of the course include not only the personal fulfillment and satisfaction of the graduate nurse. The reward is reflected in a higher level of patient care and increased communication on technical aspects by all personnel involved in unit operation. The four-week graduate course is a basic requirement for continuation of employment in the unit.

Continuous education within the unit is also necessary for continued high level efficiency. The RoCom audio-visual planned program, despite its initial high cost, permits constant review of pertinent subject material *on the unit*. The nurse is available on site for emergencies. Such a course also permits around the clock utilization and is available for evening and night shift personnel who are sometimes unable to otherwise attend lectures.

Our institution has had limited success with the telephone tape lectures provided by the Regional Medical Program. This has occurred primarily because of understaffing problems. The virtues of a teaching system such as RoCom accrue to the telephone tapes. Availability, ease of repetition, and completeness of subject material make this type of continuous education a satisfactory tool.

On-going, in-unit lectures by physicians are of importance. A curriculum once established can be repeated. The problems of a lecture series are recurrent and troublesome, but not insurmountable. The problems are availability of motivated physician-instructors and lack of constant student attendance due to changing shifts. The personal, small-group, repetitive-type instruction with opportunity for questions and amplification is the cornerstone of continuing education. We have also used the bedside case-teaching method, employing daily rounds. Rounds serve as a mechanism for observing bed utilization and over-all unit supervision and also permit the time-tested technic of teaching rounds to consolidate theory and practice.

Nurse-to-nurse teaching is effective and efficient. The unit nursing supervisor must be freed from routine patient care duties to permit full use of her time, if her dual role of administration and instruction is to be accomplished. An added benefit is constant evaluation of unit personnel, their performance, their needs, and their readiness for evening and night duty. Personnel in medical, surgical, and coronary care units should receive the same course training to ensure free flow of equally skilled nurses in all units.

A further training method is the utilization of workshops, short courses, and conventions to update skills and present new advances. It may be necessary for hospitals to accept the cost of such meetings as a normal operating expense. There has been excellent acceptance for such short training courses when the husband is permitted to accompany the nurse. We accept the married resident as a fact of hospital life. It appears we must acknowledge

the married nurse as an equally valid fact of life. A formal report of a conference or critique is not essential. It changes a refreshing experience into work, and anyway it is not necessary. Within a short period, there is nurse-to-nurse dissemination of a major portion of the new information.

Licensed Practical Nurses

A review of community hospital units in New Jersey finds no consistent policy concerning use of practical nurses. Our own experience has demonstrated that selected LPN's rapidly require a higher level of nursing skills, become able to interpret tachyarrhythmias, and can provide cardio-respiratory resuscitation. Scheduled in conjunction with the registered nurse, the LPN is an effective addition to staff and is capable of full training when appropriately selected.

Unit Technician

We have been fortunate in our own unit to have a ward clerk or secretary. There are innumerable tasks of a clerical nature which can be performed by an intelligent non-professional person. This spares skilled nursing staff and allows them to concentrate on monitoring and patient care. Our experience shows that a carefully selected mature individual can handle all routine communications and is invaluable in visitor control. Especially in emergencies, when nurses are fully occupied, a calm, and unselfish individual can clear the unit of visitors and provide comfort and reassurance. A full-time secretary is equivalent in time-performance to a staff nurse and can add immeasurably to unit-physician relations and public relations. We include the ward clerk in a substantial amount of the in-hospital training program, not in an effort to develop another partly trained individual, but to facilitate communication and indoctrination in the areas of responsibility and discipline.

Para-Medical Personnel

We have encountered para-medical personnel in only one unit. This was under "university type" control. However, in view of our

experience (in training student nurses to utilize monitors and recognize tachyarrhythmias) it seems reasonable to assume that it would be possible to train other young, well-motivated personnel to supervise monitors and recognize arrhythmias. In addition, there exists, in many areas, a pool of available intelligent personnel. Many university students are anxious for part-time employment and employment during evening and night shifts. Monitor supervision by specially trained para-medical personnel would free a nurse for more definitive or specialized nursing. We can, to be sure, see a possible disadvantage in fractionating medical personnel, each with a specific medical task until the unit is cluttered with personnel. This, perhaps, is only a philosophical objection but was the subject of discussion⁵ in a recent symposium.

Volunteers

Volunteers provide many hours of valuable service to hospitals. But the pace, the space, and the type of problems for which the unit is designed preclude the use of volunteers. Replacement of the unit technician by a volunteer would be possible only by using selection procedures in existence for other personnel. This also requires stability in job hours, attendance, and performance. Such volunteers presumably could be gainfully employed and would be worthy of consideration for the position of unit technician.

Contingent Nursing

Our initial experience with contingent personnel was disastrous. The reputation of the unit concerning critically ill patients and the need for skilled technics produced a marked feeling of insecurity and anxiety among contingent personnel assigned to the unit. Subsequently, because of marriage or family commitments, there was attrition of full-time, trained personnel, some of whom became a cadre of available contingent help. In addition, because of training programs in other hospitals and similar attrition, there has developed a small pool of available, trained contingent nurses. It is anticipated that this phenomenon will continue to grow. Success in

utilizing contingent personnel comes when we utilize only trained nurses familiar with ICU theory and practices.

Personnel Practices

Day-to-day operation will be successful only if there exists good personnel practices. The most valuable piece of equipment in the unit is the trained nurse. Of course, even in an ICU, there are personnel problems, not necessarily indigenous to the unit. These problems are heightened by the intensity of activity and the requirements of the unit.⁶

A generally accelerated pace of activity is characteristic of the unit. Emergencies become a routine occurrence. Emergencies demand utilization of skilled technics. Close attention must be paid to welfare of personnel. It is recommended that rotation of shifts be held to a minimum insofar as staffing levels permit. On the day shift there should be one nurse for every two medical patients. Surgical patients require more nursing procedures than do medical "critical" patients despite the need for monitoring the latter. Overtime should be kept to a minimum and sufficient personnel employed in the unit to permit time for in-service teaching.

Some units have a plan temporarily to transfer nurses to regular floors in order to provide a break in the constant high level physical and emotional pace. This permits "seeding" of regular floors with nurses conversant with resuscitation and intensive care. It encourages an informal nurse-to-nurse indoctrination and a degree of recruitment.

Extra pay for unit personnel is not recommended despite post-graduate training and experience. It becomes difficult to differentiate (or exclude other departments with) specialized nurses from such a pay or incentive plan. It is almost equally rewarding to build an esprit within the unit. Extra time, however, even if for teaching purposes only, should be compensated fairly.

It has been our unhappy experience to see six successive cases of pneumonitis in unit

personnel without similar intercurrent infections among the critically ill patients. We regard this event as due to the lowering of emotional and physical defenses in staff because of the pressures within the unit. It, therefore, should be of prime importance to the Director and Administration to be cognizant of the welfare of personnel.⁷

Emotional stress in unit personnel is frequently compounded by feelings of insecurity, particularly in the early months of the nurse's career in the unit. The older graduate feels insecure as she enters a new, high-level field. Young graduates (perhaps better motivated and more adaptable) develop feelings of insecurity which inversely correlate with the amount of exposure to units as a student and with the attitude of the instructors concerning the expanding role of the nurse participating in medical care. All this calls for a continuous assessment of needs by senior nursing personnel and the medical director, continuous in-service training to correct deficiencies, and constant reassurance, explanation and demonstration. All must have an awareness that the unit is a stress-producing area for personnel and that kindness, consideration, concern, and leadership will promote efficient operation and protect the welfare of personnel. Physicians commonly direct their energies to patient care. The physician in the unit must expand his role to include consideration for the care of the nurse.

Unit Director

The Intensive Care Unit should be directed by a physician. The director needs a good grasp of medicine plus administrative experience. He has to be motivated toward a successful unit and readily available to exercise his duties. Some teaching experience is a valuable asset. The position of director need not necessarily be restricted to an internist. We have seen successful units administered by anesthesiologists and surgeons. The director must be considered a department head with direct access to the medical board and the executive committee. It is not necessary that the director be a full attending physician.

Restriction of a director to the senior level may preclude active participation by a younger, more fully motivated physician. Many future directors will (and should be) young men with enthusiasm and university training in established units. The director should be given full responsibility for administering the unit and he should also have clear access, on an equal footing, to administration and other supporting departments of the hospital.

A useful mechanism is support of the director by a committee of physicians representative of the hospital staff sections (pediatrics, surgery, psychiatry) to permit collective suggestions, criticisms, introduction of new methods, and the dissemination of policy to units concerned. Meetings of such a committee should be held monthly, minutes recorded, and pertinent abstracts forwarded to the hospital administrator and concerned departments. Appropriate administrative personnel (nursing service, central supply) should meet frequently with this committee *ex-officio*.

The committee, or some of its members, should also meet with unit personnel at stated intervals under the chairmanship of the director for review of problems, procedures, and performance. Minutes should be reviewed from time to time. Members of the ICU committee should serve in rotation as a unit admission and discharge committee.

The director should have over-all supervision, direction, and responsibility of all education and training of unit personnel. He should be responsible for utilization of beds and, to a degree, of the standard of care rendered. The latter function does not mean a routine consultation or clinical follow-up of each admission. It means that he should consult, inform, discuss, educate, inspire, or politely remonstrate with other staff members to insure that histories and physicals, daily notes, prompt electrocardiogram interpretation, necessary consultations, and so on are performed in an expeditious and professional manner. The continuous gentle urging to upgrade performance on the medical staff level plus the example of high-level performance

by unit personnel will often combine to increase the quality of patient care at all levels.

The director must be responsible for and responsive to the needs of the unit personnel. The slow learner must be tutored. The insecure must be reassured. The tired must be recognized and given time to recharge. Performance must be acknowledged and superior goals encouraged. Personal problems affect performance and must be accorded dignified counsel. Above all, the health of the hard-working young girls must be preserved. It is the responsibility of the director to be present, to take time, and to care for his employees as well as his patients. We regard the total care of unit personnel as the single most important function of the director.

Many community hospitals in the future will find it necessary to subsidize the post-graduate education of directors and even provide salary. In the not too distant future, unit directors at community hospitals will be hospital-employed department heads as are radiologists, pathologists, and other department heads.

We are aware of only one legal action in New Jersey deriving specifically from administration of a unit. It is recommended that the hospital assume the cost of liability protection of the director.

Admissions and Discharges

Admission to the intensive care unit should be restricted. A mechanism should be developed which expeditiously permits clearance for admission by a physician. This requires that a physician be on call around the clock. Insofar as possible, there should be physician-to-physician contact concerning the status of the patient to be admitted. Avoid utilizing nurses, secretaries, or other third parties to relay messages. Occasionally it may be necessary, when beds are at premium, for the admitting physician actually to see the patient and personally discuss the need for admission with the attending. Clearance for admission to the unit requires an active, informed, unselfish, and available group of physicians to

support the director. The admitting physician must be constantly aware of the bed status in the unit and authorized to effect emergency discharges to accommodate admissions of more critically ill patients.

The very best managed unit can never guarantee that an admitting physician will be immediately available to provide clearance for emergency admissions. A back-up (or "second-call") admitting physician is a partial solution. A more adequate relief valve is the general policy statement that anyone (attending physician, emergency room physician, nursing supervisor, for instance) may, under exceptional circumstances, authorize an admission to the unit *provided* there is review by the unit director or his delegate and accountability to appropriate authority. Abuse of this provision, in our experience, has been rare.

Coronary care units should also admit *presumptive* coronary occlusions. An absence of a degree of diagnostic error may indicate that the unit is not fulfilling its role. A corollary is that all hospital admissions with the diagnosis of coronary occlusion, proved or presumptive, should be admitted to the unit for care. The unanticipated resuscitation of an acute coronary occlusion on a general floor should be considered, at the very least, an embarrassment, and subject to review and accountability.

In the community hospital, it is unwise to exclude the coronary occlusion with associated peripheral vascular collapse though this is the policy in some teaching institutions. The prognosis is grave, but the utilization of the intensive care unit is rewarding in experience gained and in serving the needs of the community.

Problems in coronary care units arise with the admission of non-coronary critically ill patients. Arrhythmias, pulmonary edema (with and without underlying myocardial infarction), intractable congestive failure, and hypertensive crises are an extension of the role of the coronary care unit. The unit in the

community hospital should expect to serve this type of case in view of the shortage of personnel on general floors, the level of training on such floors, and the expectations of the attending physician and the public once a unit is established and functioning.

The admission policy in combined units presents a somewhat different problem than in the unit devoted exclusively to coronary occlusions. Here we face a problem in definition and this is eventually negated by making comparison between sick, sicker, and sickest. The type of case recognized by Blue Shield as involving "critical care" (and, therefore, a criterion for higher recompense) serves as a limited guide. However, no two cases are exactly similar. In our institution we have developed the following general policy: "Provided a bed is available, critically ill patients will be admitted to the unit whose admission will benefit the patient by utilization of special equipment, training, or techniques or whose admission will benefit the hospital." In the combined intensive care units (surgical and medical) three policy provisions exert a measure of admission control: (1) the necessity to request clearance, (2) the need for mandatory consultation and, (3) the requirement that the patient be placed on the critical list and the family so informed. In some places, the tendency is to request admission for all dying patients. This becomes demoralizing to the nursing personnel who are oriented to resuscitation. It denigrates the reputation of the unit and produces fear in patients. The unit is a "recovery" unit. This insidious tendency should be resisted.⁸

Most patients with a coronary occlusion are suitable for discharge three to five days after admission. Tachyarrhythmia lasting longer than five days does not present a problem in evaluation. The expressed or tacit admission of "no pacemaker" also ordinarily precludes continuation in the unit. The high level of care frequently seduces the attending to try for "one more day." This, however, is frequently contravened by the patient himself who recognizes his own improvement and becomes concurrently aware of the pace of the

unit and the lack of convalescent amenities (visitors, television, and so on). Telemetry to monitor discharged patients on general care floors will make the discharge of the coronary patient easier.

Discharge by transfer of other intensive care patients can be done only on an individual basis. Experience has shown that attending physicians become acquainted with the efforts to provide beds for their emergency admissions and subsequently are cooperative with their discharges. An awareness of the daily surcharge is also provocative. In difficult cases, the upturned, questioning face of the prettiest nurse is usually effective in obviating disciplinary measures.

Patient Care

Patient care in the intensive care unit is *not* routine. It is necessary to adjust time-honored habits of nursing technics for several serious reasons. Admissions can occur at any time. Patients are almost always very critically ill and frequently *in extremis*. In the unit, emergencies which require all-out efforts for resuscitation involving all hands do occur frequently. Therefore, dislocations of routine nursing schedules are common. Subject to change are standard or exceptional body care procedures, meal routines, and the report and the writing up of notes. Also subject to change in scheduling is the assignment of patients to a particular nurse. All care becomes non-routine, geared to the needs of the patient. Unit personnel must be adaptable and must adjust constantly. "This is not the way I used to do it" is a common statement by new personnel without prior unit experience. Unfortunately, "this is not the way you're supposed to do it" is also a common statement of older supervising personnel. It requires time, experience, and mediation to adjust the conflicting points of view. Complete harmony, perhaps, will not be achieved until the time when all nursing directors and supervisors have had ICU experience. In the meantime, one needs to fall back on the aphorism, "the patient comes first."

Care is constant. The unit may never be

left unattended. It requires a minimum of two trained people to institute any kind of successful resuscitation. An unwatched monitor is useless. Successful patient care requires a high degree of continuous observation. Patient care in the unit also calls for a high degree of specialized skill. Cardio-respiratory resuscitation (CPR) requires practice and training, training and practice. The reaction to emergencies should be a swift response with an instantaneous mental sorting of alternatives, extreme physical activity, and controlled emotion. CPR must be virtually silent communication, since it is known that many patients initially have a heightened awareness of their experience, as reported in *Lancet* by a physician who experienced an arrest. Patient care thus requires a high level of special skill achieved through constant training.

The development of special CPR technics is expanding. A coronary care unit does not deserve this title unless defibrillation of ventricular arrhythmias is possible. This requires full training. In the community hospital, this means nursing personnel. Training to certification in this and all other technics is mandatory. Apprehension concerning incursion into the "privileges" of the physician and the legality of the methods must be allayed. We must anticipate the development of new methods, bring them rapidly to the community hospital level, and promote their acceptability. We must be willing to urge change in professional licensing laws to permit utilization of new technics as the role and responsibility of the nurse changes and increases.

Great rewards accrue to the development of an attitude of courtesy, kindness, consideration, and education of the patient. One can only read the essay titled "Risk" by the sensitive writer Rachel MacKenzie⁹ to be aware of the effect of failure to provide reassurance and education to the cardiac patient. Humor in daily communication is important. Relating to the patient (whether by use of the first name, or any other means) is important to maintain the ego structure overwhelmed by

illness. Depression is a frequent concomitant finding and this should be recognized. Knowing this, we tried to establish a cross-pollination program between nurses in psychiatry and ICU nurses. It met with little success. The psychiatric personnel recognized the need for re-education in resuscitation. Objections to the program were raised by many of the ICU personnel. This was due, in part, to the apprehension and demands encountered by the low staffing current at the time. The program involving such an interchange, however, still has merit.

The same qualities of compassion, kindness, and understanding are necessary in relations with relatives. Uncontrolled visiting by an anxious family can be detrimental to patient welfare and a handicap to ordinary care and to resuscitation. The needs and anxieties of the family are described by the novelist, Lois Gould in *Such Good Friends*.¹⁰ The unit secretary (clerk) can assume a major role in visitor control and reassurance, thereby relieving the nurse. It should be the attending physician's role both to provide major report and reassurance to the families and assist in relieving the nurse of this particular task.

Among unit personnel we recognize a "fatigue factor." This can be relieved by some of the principles discussed in the section on personnel practices. The welfare of unit personnel must be cause for continuous concern and supervision. Slow days in the unit do occur. They must be utilized for restocking of both supplies and emotions. It is demoralizing to regard personnel as supernumerary on slow days and to "pull" them off the unit to supply other floors.

Units must be goal oriented. The goal is to provide exceptional care. In a time of early obsolescence and inferior craftsmanship, the magical aura of being the best is desirable. We know of no secret method of creating that aura, but it can and should be encouraged.

Relations to Other Departments

It is the responsibility of the director and the head nurse to develop and maintain good

communications with other departments in the hospital. The presence of the chaplain should be welcomed. Time spent in acquainting him with principles of treatment and care is well rewarded by enhanced understanding, assistance, and compassion by both unit personnel and the chaplain. It is encouraging to see the expansion of curriculum by divinity schools as well as the in-service post graduate courses provided by hospitals.

Other departments may not really understand "non-routine" care. It is a problem to the dietitians to provide irregular meals and an even greater problem to housekeeping services to meet repeated irregular calls for service necessitated by unexpected transfers and the imminent arrival of a new admission. These requests are complicated by union contracts and rigid personnel policies which control overtime, holidays, and the like. A practical solution has been the inclusion of such service personnel into the "special team" aspect of the unit with concomitant expressions of appreciation by personal word and written commendation.

Professional departments such as laboratory and x-ray present special problems. Because of the special work load of the unit, *stat* requests are frequent but are understood to be valid. The situation is ameliorated by training unit personnel to perform venipunctures and perform certain tests within the unit thereby diminishing some of the *stat* work load. Special markings on requisitions permit early scheduling and early reporting of unit requisitions. The problem requires, as do many others, the opening of lines of communication.

Central service burdens can be ameliorated by stocking, if storage is available. Special equipment can be stored in the unit under lock and key with close inventory control. Constant surveillance of electronic equipment by the engineering or medical electronics department is essential. Evidence¹¹ is accumulating concerning current leaks and the effect on patients with a damaged myocardium.

We have no special expertise for dealing with engineers other than to state that an awareness of what may be desirable often is hideously expensive. Costs and practicability are the province of the engineer and not the physician. Engineers are delighted by problems that are classified as totally insoluble by the physician.

Medical Care

A set of standing orders, approved by the medical staff, is an expeditious and efficient means of initiating care and providing a check list for diagnostic and therapeutic procedures. A standard published routine for resuscitation is effective. Both, however, should be counter-signed by the physician and should be amenable to alteration by the attending. Efficiency is increased by utilizing a complete up-to-date and amendable procedure book as a means of maintaining a high level of care. The standard operating procedures are written and publicized by physicians for physicians.

In view of the critical nature of illness and the emotional reaction of families, the hospital bylaws concerning consultation are automatically enforced. Use of the standard hospital bylaw concerning a consultation for critical patients removes the onus from the unit personnel in suggesting compliance. Doctors should be sufficiently cognizant of the achievement in training by unit personnel so that they become confident in granting routine signed permission for procedures such as venipuncture, administration of anti-arrhythmic agents, and defibrillation.

Written, published, standard procedures must include prompt visit to the patient by the attending, full daily progress notes, and daily interpretation of electrocardiogram. Such (usually self-imposed) discipline encourages a high level of patient care and is a factor in communication with nursing personnel which permits more complete continuing evaluation of the patient. In our experience, the single most desirable factor on the operation of a unit is complete communi-

cation between the attending physician and the nurse. The unit demonstrates a new partnership between physician and nurse which should be an important guideline for future in-patient care.¹²

All physicians benefit from the higher level of care rendered to their patients, and all physicians should overcome reluctance to teach in the unit. To teach is to learn.

Cardio-Pulmonary Resuscitation

Resuscitative procedures are now common and reasonably standardized. A critique of every arrest should be held with ICU, floor, or ER personnel to review the procedures used. This is for constructive criticism. The ICU director or members of the ICU committee should serve a more important function as critical observers, whenever adequate personnel are available to care for the emergency. This provides a more dispassionate direction and a higher degree of objective analysis. Too many staff physicians have *not* received training in cardio-pulmonary resuscitation. It is demoralizing to staff, a legal liability, and probably unethical for any physician to be untrained in rendering emergency care. A training program for physicians should be mandatory to retain hospital privileges. Policemen, firemen, and ambulance drivers are trained in cardio-respiratory resuscitation. There is no reason to preclude education of auxiliary hospital personnel in emergency procedures. Maintenance personnel are exposed to industrial hazards. We have seen arrest in the cafeteria, physiotherapy, and the parking lot. It should be expected that anywhere within the hospital environs, CPR should be available. We know of successful resuscitations in which a second year nursing student, an orderly, and a recent graduate nurse participated. Therefore, it can only be concluded that trustees, administrators, physicians, regardless of specialty, nurses, and all other hospital personnel, in every department, should be able to initiate resuscitative measures. It has also been observed that all hospital personnel are heart-oriented rather than airway conscious. It is

upsetting to see vigorous cardiac massage performed without an airway in place or efforts made to provide oxygenation. To correct this we have taped airways in our nurses' stations and requested ICU personnel to carry airways together with their scissors. It is a simple way to reinforce the respiratory part of CPR.

Printed checklists detailing step-by-step function of the appropriate personnel involved in resuscitation should be attached to all equipment, such as crash carts and defibrillators; these should be visible at every nurses' station and in all procedure books. When new personnel initial or sign the procedure book, this is a stimulus to attentiveness.

Cardio-respiratory resuscitation is a reasonably standardized procedure and suitable training courses are readily available. But it must be the concern of all hospital personnel to be continually aware of improvement in technics.

Conclusion

We have surveyed some of the problems encountered in the operation and organization of a community hospital intensive care unit. The success of a unit will depend upon the extent of the training of the personnel. Every means of training should be utilized. Equipment is secondary to training. The most valuable item of "equipment" is the nurse. The care and welfare of dedicated and hard-working, young women, exposed to physical and emotional strain, is of paramount importance.

The unit should be administered by responsive and responsible physicians. The ultimate burden of patient care will always return to the shoulders of the physician. All other departments must be considered supportive and responsive to medical direction. The abdication of responsibility by physicians in the operation of intensive care units can result only in lowered patient care and diminished success.

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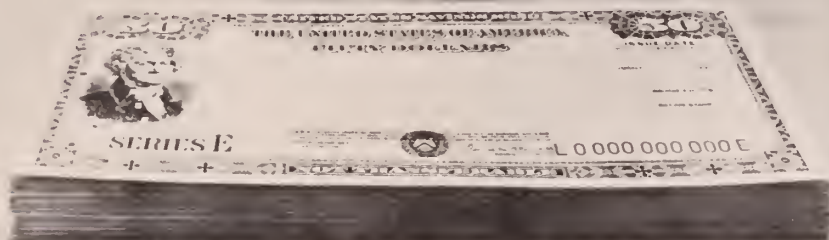
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coliform bacteria

Klebsiella

Proteus mirabilis

Loridine also has demonstrated activity against *Treponema pallidum* in experimental syphilis studies in animals.

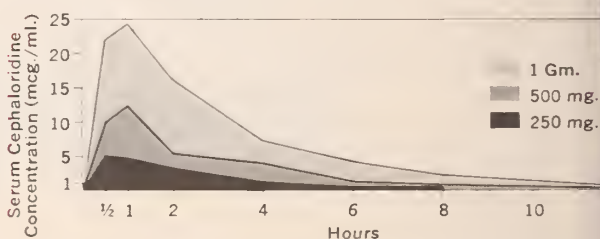
All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine. However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *H. influenzae*, *Pr. mirabilis*, *Esch. coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

*Loridine is indicated in the treatment of gonorrhea when penicillin is not considered the drug of choice.

Facts about dosage

In adults, most infections of moderate severity caused by susceptible organisms respond to Loridine in dosages ranging from 500 mg. to 1 Gm. every eight hours (1.5 to 3 Gm. daily). This use of lower dosages helps prevent drug accumulation. The more susceptible infections have been treated with 250 to 500 mg. every eight hours.



Mean Serum Cephaloridine Concentrations after I.M. Administration Single Doses (250 mg. to 1 Gm.) to Normal Human Volunteers (Six Eighteen Subjects per Group). (Modified from Currie, J. P.: Cephaloridine: Pharmacology and Toxicology, Postgrad. M. J., 43 [Supplement 22, 1967].)

Peak serum levels have been noted with Loridine with one-half to one hour following I.M. injection. The mean peak serum levels obtained in normal subjects one hour after a 500-mg. I.M. dose ranged from 12 to 22 mcg. per ml. in separate studies. Administration every six to eight hours permits adequate concentrations to be maintained. In order to avoid excessive serum levels (which could possibly result in damage to the kidney tubules), recommended dosages should not be exceeded. In adult patients without azotemia who have mildly reduced renal function manifested by slight to moderate transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the maximum recommended dosage is 1 Gm. every twelve hours during the period of reduced function.

Facts about administration

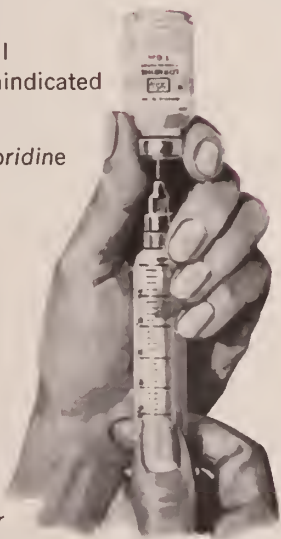
The following guidelines for therapy with Loridine are recommended.

Before Administration of Loridine

- Establish susceptibility of the pathogen.
- Determine patient's renal status; Loridine is contraindicated in azotemia.

During Administration of Loridine

- Maintain proper hydration.
 - Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
 - Use cautiously with other potentially nephrotoxic drugs.
 - Because nephrotoxicity has been reported, limit dosage to 4 Gm. daily for adults (100 mg. per Kg. for children—not to exceed adult dosage).
- Usual adult dosage range: 1 to 3 Gm. daily.



- In patients with impaired renal function before treatment, reduce daily dosage and keep them under close observation for changes in function. In nonazotemic patients with mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage (adults) is 1 Gm. every twelve hours during the period of reduced function.
- In patients who develop impaired renal function or whose preexisting impairment becomes worse during treatment, discontinue therapy.

Since Loridine is relatively painless on I.M. injection, it is well accepted by patients.

There is clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins; therefore, Loridine should be used with great caution in patients with known penicillin allergy. Instances of patients who have had severe reactions to both drugs, including death from anaphylaxis, have been reported.

 **Loridine[®] I.M.**
cephaloridine



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(Please turn page for prescribing information.)

Loridine® I.M.

cephaloridine

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred

in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of .30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

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The physician sees the child long before the dentist does, and thus has a unique opportunity for service.

The Physician's Dental IQ

And Why It Should Be Raised

Paul Duboff, D.D.S./Jersey City*

Dentistry is a highly specialized area in medicine and has its roots in the same academic soil. The dental student is trained in the basic medical sciences, such as gross and microscopic anatomy, physiology, microbiology, and pathology. He then devotes the bulk of his remaining school years to strictly dental subjects. Accordingly, the dentist graduates with a reasonable knowledge of the inextricable medical/dental relationship. He realizes that he could not practice any phase of dentistry without this basic medical training.

The physician, alas, *can* practice his art and science with little or no knowledge of dentistry. Too often, a physical examination of the patient begins with the fauces and pharynx, but ignores the oral cavity. Advanced caries, dental abscesses, periodontal disease and neoplasms can go unobserved. These unseen diseases may cause only slight discomfort to the patient at later times. They might also conceivably cost him his life. The U.S.P.H.S. states that the incidence of oral cancer has increased 39 per cent faster than the population growth in the past 50 years. Purpose of this essay is to alert the physician to the great need for a more critical appraisal of the hard and soft tissues of the oral cavity and surrounding areas and to urge him to accept his responsibilities and increase his diagnostic acumen in this area. It is hoped that this paper will be received in the spirit with which it is written—that is, one of reciprocal respect and cooperation between medicine and dentistry. A higher index of suspicion regarding oral disease would be desirable by both physicians and dentists. Complacency and fa-

miliarity with a particular area of the body are no excuses for inadequate examination.

Many excellent texts and atlases are available on the subjects of oral pathology, medicine and diagnosis.¹ It is sufficient for this paper to indicate the broad areas of pathology and leave it to the individual reader to seek out more definitive information.

Consider lesions of the teeth, periodontium, and soft tissues of the oral cavity. Grossly carious or broken teeth are easily detected on routine examination. Lesions of the periodontium can run the gamut from simple gingivitis to advanced periodontal disease. Oral manifestations of such diseases as diabetes and leukemia are often seen in the gingiva. Lesions of the soft tissue of the oral cavity may be neoplastic, or systemic, such as syphilis or gonorrhea. The oral diagnostician must examine and evaluate the tongue, lips, neck, palate, oro and naso-pharynx and fauces.

Dental illness is the most prevalent disease in the world today. The physician sees infants from the day they are born, whereas many parents do not bring a child for his initial dental visit until he is 7 or 8 or until his first dental crisis. During these early years with its numerous doctor/patient contacts, the M.D. has many opportunities to examine the child's dentition and gingiva. It is actually possible to prevent a third of all orthodontic cases by maintaining the primary dentition intact until the teeth are naturally shed. Pre-

* Assistant Professor of Oral Diagnosis and Radiology, College of Medicine and Dentistry of New Jersey.

senting information on this matter and a prescription for fluorides to the parents would go a long way in helping the child develop a healthy dentition.

A fact not commonly recognized (even by many dentists) is that periodontal disease *can* exist in children. Chronic gingivitis due to inadequate or ineffective hygiene can lead to early bone loss with tragic results. More teeth are lost after age 35, due to periodontal disease than to caries. Periodontal disease is insidious. The person with a low caries index could conceivably go through most of his adult life without ever visiting a dentist. When his condition is eventually discovered, it may have progressed beyond the point of treatability.

Many adults consider the loss of their teeth to be inevitable. After all, their parents and grandparents had "plates." Modern dental technics make this point of view completely

out-dated. With the methods available today a person should be able to keep all his teeth for his life, unless there is loss from trauma or surgical removal of impacted teeth.

The physician who has a working knowledge of endodontics, periodontics, prosthodontics, pedodontics and restorative dentistry can advise and guide his patients to seek out those dentists who can best help him maintain his oral cavity in a state of total health. Close cooperation between physician and dentist is the ideal toward which we must all strive.

1. Among recommended texts are Donald Kerr: *Oral Diagnosis*, Mosby, 1970; Edward Zegarelli and Austin H. Kutscher: *Diseases of the Mouth and Jaws*, Lea and Febiger, 1969; John H. Manhold, Jr. and Theodore E. Bolden: *Outline of Pathology*, Saunders, 1960; Paul E. Boyle: *Histopathology of the Teeth and Surrounding Structures*, 4th edition, Lea and Febiger, 1957; Samuel C. Miller: *Oral Diagnosis and Treatment*, 3rd edition, McGraw-Hill, 1957; Kurt H. Thoma and Henry M. Goldman: *Oral Pathology*, 5th edition, Mosby, 1960; and Robert A. Colby, Donald A. Kerr, and Hamilton B. G. Robinson, *Atlas of Oral Pathology*, 2nd edition, Lippincott, 1961.

201 Corneilson Avenue

Measuring Drugs for Depression

A simple chemical test for assessing the efficacy of certain drugs in the treatment of depression has been announced by HEW's National Institute of Mental Health, Health Services, and Mental Health Administration. The study focuses on monitoring the pharmacologic activity of the tricyclic drugs often used in treating depression. These include imipramine, amitriptyline, and others. The project director is Dr. Seymour Rosenblatt of the Mount Sinai School of Medicine, New York City. Therapists estimate that between four and eight million Americans are in need of professional care for a depressive illness at any given time. The test consists of administering a small tracer dose of norepinephrine and determining the relative distribution of unoxidized amine (N) and oxidized (O) metabolites (N/O ratio) in a urine specimen collected 12 to 20 hours later. This test is

easier and provides more precise data than the blood tests now used.

Previous research has implicated norepinephrine as a possible factor in depression. The illness has been associated with a deficiency of the transmitter hormone in the central nervous system. The tricyclic drugs may be effective against depression because they somehow correct an "error" in central nervous system functioning which too rapidly depletes the available supply of norepinephrine. Dr. Rosenblatt will study to what extent the N/O ratio in urine correlates with patient improvement, whether pretreatment N/O ratios may indicate if a patient will do better on other than a tricyclic drug, and whether the ratios will allow an early evaluation in the patient's treatment of the efficacy of a particular tricyclic drug.

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All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications** are listed above. **MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with $\frac{1}{2}$ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

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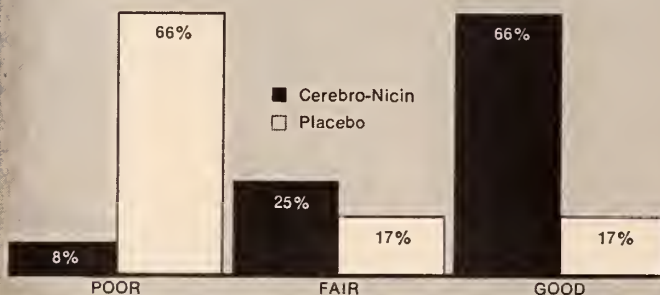


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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

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Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.



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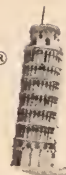
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.



The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970 Official Journal of the American Fertility Society

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Dose: 1 tablet 3 times daily.
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Calcium Pantothenate . . 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.
Dose: 2 tablets daily
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hypertension. Occasional cases of jaundice with plugging of biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting, abdominal pain, diarrhea, headache, dizziness, tinnitus, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration. Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone in particular elderly patients, should be observed for edema. Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montazano, P. and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1965. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Telford, A. S. Methyltestosterone thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Matsumoto, L., Bradley, H. L., Zimhoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interactions and the psychopharmacologic effect of androstenedione. J Clin Endoc 19:906, 1959. 5. Farns, E. J., and Collier, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osai, A., and Farrar, W. E. United States Dispensary and 25. Lippincott, Philadelphia, 1955, p. 1432. 7. Wersshak, L. P. Sexual impotence in the male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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The common label "alcoholic" covers a varied spectrum of psychiatric problems.

Characteristics of Male Alcoholics

Earl X. Freed, Ph.D./Lyons*

Symptom patterns and the presenting complaints of patients admitted to a psychiatric hospital are important data in diagnosis, prognosis, the strategy and goals of treatment, an understanding of the breakdown which led to hospitalization, and the attitudes of hospital personnel toward the patient. Horn and Wanberg¹ found different symptom patterns among patients admitted to a psychiatric hospital because of problems associated with the use of alcohol, implying that perhaps different "types" or syndromes required different treatment programs. In a less detailed analysis, Freed² reported a relative commonality of certain problems and complaints upon admission of alcoholics to a mental hospital. These bore a strong resemblance to those noted by Schwarz and Fjeld³ among alcoholics in the emergency room of a psychiatric hospital. All of the foregoing relate to the specificity theory of alcoholism⁴; that alcoholics may have different personality traits than other psychiatric groups.

This study sought further data on the question by comparing the symptomatology and characteristics of alcoholic and non-alcoholic patients upon admission to a psychiatric hospital.

Subjects of our study were 650 male veterans admitted to the Lyons Veterans Administration Hospital. This is a large psychiatric facility. In half of the cases, mention of alcohol abuse or a history of alcoholism (often in addition to other significant psychopathology) was made in the admission note or pre-

liminary staff note. We reviewed these psychiatric notes which had been dictated upon admission or immediately after presentation of the patient to the preliminary staff conference. The latter usually occurred from one to four days after the admission. As the short notes preceded a detailed and comprehensive examination and history they were, perforce, limited to the recording of outstanding symptomatology, complaints, precipitating and predisposing factors, and assets with which to work in treatment. Therefore, as Freed² noted, "it is not unreasonable to assume that material contained in the initial, short report may be regarded as . . . important and dramatic data in describing the patient, his problems, his illness, and its impact upon his life, especially as it culminated in his current hospitalization."

Preliminary review of the notes by three raters revealed substantial agreement on a number of frequently occurring categories of complaints, symptoms, and personality characteristics. Frequently counts of these, for each of the subjects, were made by one of the raters and converted to percentages. The significance of the difference between the ratios of psychiatric patients who did and who did not manifest alcohol abuse was calculated for each category by the method of Edgerton and Paterson⁵.

Results and Discussion

Forty-six symptoms or characteristics appeared with sufficient frequency to be tabu-

*This work is from the Veterans Administration Hospital at Lyons, New Jersey; the coauthors are Diana G. Triplett and Edward P. Freeman

lated. Twenty of these differentiated between patients who did and who did not manifest alcoholism minimally at the five per cent confidence level, which was adopted as indicative of statistical significance. Twelve symptoms (Table I) were found significantly more frequently among alcoholic patients, eight (Table II) more frequently in the non-alcoholic group, and twenty-six (Table III) were distributed non-significantly among the two groups.

At least one-quarter of the total sample of 650 men displayed inappropriate affect, anxiety, tension, hostile behavior, and depression, had somatic complaints, evidenced delusions or hallucinations, had multiple psychiatric hospitalizations and vocational problems, and were being readmitted to this hospital

TABLE I

Symptoms Found in a Significantly Greater Percentage of Alcoholic than Non-Alcoholic Patients

Symptom or characteristic	Per cent Alcohols	Per cent Non-alcohols	Level of Significance
Tremulous	19.7	1.9	.0002
Delirium tremens	8.3	0.0	.0002
Alcoholic brain syndrome	5.9	0.3	.0002
Anxious	27.7	16.6	.0006
Lost control of drinking	4.0	0.0	.001
Separated or divorced	7.4	2.5	.002
Readmitted here within a year	35.1	24.3	.000
Depressed	48.6	36.9	.003
Gastrointestinal symptoms	14.5	7.4	.003
Denies problems	12.3	6.5	.009
Family conflicts	21.5	15.4	.04
Impaired memory	10.8	6.5	.04

TABLE II

Symptoms Found in a Significantly Greater Percentage of Non-Alcoholic than Alcoholic Patients

Symptom or characteristic	Per cent Alcohols	Per cent Non-alcohols	Level of Significance
Inappropriate affect	18.5	33.2	.0002
Delusions and/or hallucinations	27.1	41.5	.0002
Drug abuse	0.6	4.9	.001
Confused	12.0	20.3	.004
Flattened affect	3.1	7.1	.02
Uncooperative during interview	2.2	5.5	.03
Regressed	1.9	4.9	.03
Incoherent	0.3	2.5	.05

TABLE III

Symptoms which Failed to Differentiate Significantly between Alcoholic and Non-Alcoholic Patients

Symptom or characteristic	Per cent Alcohols	Per cent Non-alcohols	Level of Significance
Agitated	13.5	19.1	.06
Vocational problems	30.5	24.3	.08
Tense or fearful	40.0	33.5	.09
Intellectual impairment	2.8	5.2	.10
Poor insight or judgment	8.6	12.6	.11
Somatic complaints	30.2	24.9	.13
Stopped taking medication	11.1	7.7	.15
Poor contact with reality	4.9	7.7	.15
Destructive	4.3	2.5	.17
Conflicts with the law	14.5	11.1	.18
Withdrawn	4.9	7.4	.18
Suicidal trends	22.2	18.2	.20
Sexual difficulties	3.4	5.2	.22
Hostile behavior	27.4	23.7	.29
Impaired abstract ability	13.2	10.8	.34
Non-alcoholic brain syndrome	1.2	2.2	.36
Insomnia	17.5	15.1	.38
Extended prior hospitalization	3.1	4.3	.38
Poor self-concept	5.5	4.3	.53
Physical illness	8.6	9.9	.60
First psychiatric hospitalization	18.5	19.4	.76
More than one previous hospitalization	53.9	54.8	.82
Disheveled appearance	4.9	4.6	.86
Psychomotor impairment	7.7	8.0	.88
Financial problems	3.7	4.0	.98
Guilt feelings	4.9	4.9	—

less than one year after discharge. This patient sample was composed of a chronic group with a history of numerous hospital admissions.

Despite this commonality of symptoms, there was some support for the hypothesis of the uniqueness of the alcoholic in that many of the symptoms occurring significantly more frequently among the alcoholics were directly referable to acute and chronic sequelae of overindulgence. On the other hand, the non-alcoholic group's significant symptom pattern was much more suggestive of a syndrome of schizophrenic regression even though subsequently a number of the alcoholics also were diagnosed schizophrenic.

The well-documented family and marital conflicts of the alcohol abuser are reiterated

by the data in Table I. The poor vocational adjustment of both groups is highlighted in Table III; an outstanding consequence of emotional maladjustment is a disturbed work life.

An interesting finding is the lack of narcotic drug abuse among the alcoholics. One may speculate whether alcohol abuse and abuse of other drugs are equivalents. Both groups of patients evidenced much tension, anxiety, fearfulness, and depression, affects hypothesized to underlie both alcohol and drug abuse.

One conclusion from these data is that patients manifesting alcoholism as one aspect of a broader psychopathology present a somewhat atypical symptom pattern upon admission to the hospital. To the extent that alcoholic admission characteristics represent acute consequences of alcohol abuse, one might expect a more rapid remission of symptomatology than among non-alcoholics who are primarily schizophrenic. Different initial treatment programs would appear to be in order, then. With the alcoholic, detoxification constitutes a first step, readying the patient for rehabilitative procedures aimed at more basic psychodynamic problems perhaps masked by the presenting symptomatology referable to alcohol abuse. The heterogeneity of symptomatology in the alcoholic group offers some support for Wanberg's and Horn's conclusion⁶ that "different alcoholism dimensions will require different treatment ap-

proaches," and for Freed's thesis⁷ that "a wide variety of patients with as yet unelucidated underlying psychiatric conditions might be loosely grouped under the rubric of 'alcoholic'."

Summary

Behavior characteristics and symptoms of 325 male alcoholics and 325 non-alcoholics were rated upon their admission to a Veterans Administration hospital. There was some support for the hypothesis of the uniqueness of the alcoholic patient. Many of the symptoms occurring significantly more frequently among alcohol abusers were directly referable to acute and chronic sequelae of overindulgence. There was also evidence of underlying psychopathology masked by the more blatant alcoholic symptomatology.

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single-dose treatment for intramuscular use only

a chemically distinct antibiotic indicated specifically
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in the male—acute urethritis and proctitis
in the female—acute cervicitis and proctitis
when due to susceptible strains of *N. gonorrhoeae*

High cure rate: *96% of 571 males, 95% of 294 females

(Dosages, sites of infection, and criteria
for diagnosis and cure are defined on page 3 of advertisement)

Assurance of a single-dose, physician-controlled treatment schedule

**No allergic reactions occurred in patients with an alleged history
of penicillin sensitivity when treated with Trobicin,
although penicillin antibody studies were not performed**

Active against most strains of *Neisseria gonorrhoeae* *in vitro*
(M.I.C. 7.5-20 mcg/ml)

**A single two-gram injection produces peak serum concentrations
averaging about 100 mcg/ml in one hour**
(average serum concentrations of 15 mcg/ml present 8 hours after dosing)

NOTE: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

For full prescribing information, including contraindications, warnings and precautions, please see last page of this advertisement.

*Data compiled from reports of 14 investigators.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

Trobicin and the gonorrhea challenge

An accelerating epidemic— a decelerating susceptibility to penicillin

Gonorrhea is now the most prevalent reported communicable disease in the nation. The estimated number of new cases of gonorrhea in the United States exceeded two million for the first time in 1970. To compound the problems, strains of *N. gonorrhoeae* increasingly resistant to penicillin and other antibiotics are appearing throughout the country. Schedules of treatment which were effective only a few years ago now result in a significant percentage of treatment failure. *In vitro* studies have demonstrated that resistance of *N. gonorrhoeae* may also develop to Trobicin.

Thus, while aqueous Procaine Penicillin G remains the drug of choice for the majority of patients, the need for a non-penicillin, intramuscular antibiotic for acute gonorrhea in the male and female is abundantly clear. Such an antibiotic should be effective following a single intramuscular injection—and it should not demonstrate cross-resistance with penicillin

Trobicin—a new alternative specifically for the treatment of acute gonorrhea

Trobicin is indicated in the treatment of acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

High cure rates:

96% of 571 males, 95% of 294 females

Clinical Results with Single-Dose Treatment, Intramuscularly* (Data compiled from reports of 14 investigators**)

	Dosage	Number of Patients	Number Cured	Percent Cured
Adult Males: Gonorrheal urethritis	2 grams	475	457	96%
	4 grams	96	93	97%
Adult Females: Gonorrheal cervicitis	4 grams	294	280	95%

Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin medium in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluable and were not included in the table above.

No allergic reactions occurred in patients with an alleged history of penicillin hypersensitivity when treated with Trobicin, although penicillin antibody studies were not performed.

Chemically distinct

Trobicin is structurally not related to any other antibiotic commonly used to treat gonorrhea.

The assurance of a single-dose, physician-controlled treatment schedule

Intramuscular injections should be made deep into the upper outer quadrant of the gluteal muscle.

Adult male: Single 2 gram dose I.M. in acute gonorrheal urethritis. Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in gonorrheal proctitis and in patients being re-treated after failure of previous antibiotic therapy. In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams intramuscularly is preferred.

Adult female: Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in acute gonorrheal cervicitis and proctitis.

Safety for use in pregnancy has not been established, nor has safety for use in infants and children.

The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

*4-gram doses were injected in two gluteal sites.

**Medical Research Files, The Upjohn Company

a chemically distinct antibiotic indicated
specifically for treatment of
acute gonorrheal urethritis and proctitis in males
and cervicitis and proctitis in females
when due to susceptible strains of *N. gonorrhoeae*

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STERILE SPECTINOMYCIN DIHYDROCHLORIDE
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(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injection: 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.

Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic re-

sistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—single 4 gram dose (10 ml) intramuscularly.

How supplied: Vials, 2 and 4 grams —with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

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Here is one man's view on the problem of the U.S. citizen in a foreign medical school

Guadalajara and the Foreign-Trained Physician

S. William Kalb, M.D./East Orange

I was interested in the Future Physicians' program which was initiated by the Essex County Medical Society and later adopted by the AMA as its recruiting arm among high school students in the United States. I visited Guadalajara to find out why so many American students migrated there to study medicine.

When I asked the Dean of the Medical School (Dr. Joaquin Ramos Santos) why they admitted so many American students he replied, "Our doors are open to all—we ask only that the student is motivated and wants to study medicine more than anything else. Our hope is that our students will give comfort to the diseased and the physically disabled. We have no room here for long-hair, bearded students, radicals, or flunk-outs."

There are over 3,500 medical students in this school of whom 936 are from the United States. Requirement for admission here is the same as in the States. They must have a B. A. or B. S. in the biologic sciences, pass the College Admission Test (MCAT) in the United States, have a knowledge of Spanish, and, by the end of the first year, pass a proficiency examination in Spanish language and comprehension, Mexican history, and Mexican geography. About 10 per cent of the American students fail at the end of the first year.

This is a private university (not government controlled) and is part of the National Autonomous University of Mexico. One of the

largest universities in Mexico, it is funded by the Alliance For Progress and is presently near the end of construction of a \$30,000,000 campus. They recently opened the new library with 34,000 volumes and over 200 medical and scientific journals in both English and Spanish. The medical school is located in two modern, three-story basic science complexes. There are fully equipped laboratories, animal research facilities, and a large anatomy dissection room with 27 tables and closed circuit television. The auditorium seats 400. Some 175 New Jersey residents attend this medical school.

Students in groups of 15 attend clinics in 20 hospitals. A new 400 bed teaching hospital is adjacent to the medical school. It will be finished in about a year. The University City will be completed within the next two years and will be an innovation in Latin American education.

The University maintains a full-time teaching staff in the basic sciences. Most of the professors have M. D. degrees and many have a Ph.D., and additional degrees in their specialties. Every teaching assistant has a master's degree or a doctorate. Clinical training is supervised by the full-time basic science staff, supplemented by clinical attending physicians.

Practically every state in the Union is represented here and students come from many of the finest colleges and universities. Today about 4,000 American students are enrolled in foreign medical schools. The cost to educate a student in an American medical college is \$16,000. Much of this is contributed by

our government. If we were to assess the amount we would have to pay to educate the students who are now in foreign medical schools, it would amount to over \$100,000,000.

The Educational Council For Foreign Medical Graduates (ECFMG) has ruled that a student, in order to qualify for an internship in a United States hospital, must satisfy the requirements for licensure in the country in which he studied medicine. Here, in Guadalajara, this meant that after graduation the student would do a one year internship and then an additional year in (Social Service) practice in a remote village. At the end of these six years he would be eligible to intern for another year in an American hospital, after passing his ECFMG exams. A certificate would be issued which would permit the United States hospital to accept him for internship. This actually means seven years would elapse from the time he entered medical school until he could either take a residency or be licensed to practice.

At the suggestion of the ECFMG Examining Board, a four-year program was recently initiated replacing a six year curriculum to conform to United States standards. The ECFMG promised to certify the graduate for examination when he received his diploma. This would enable him to intern in the United States. The agreement was that a diploma would be issued with a degree of "Physician and Surgeon." Then the ECFMG, for some unknown reason, reversed its position and demanded that the students stay in Mexico for six years instead of four before they would allow the graduates to intern in the United States.

Hospitals in the United States are threatened with a loss of accreditation if they accept foreign medical graduates without a certificate from the ECFMG. Since the ECFMG came into existence it has gone far afield from its original intent. The Council has been running around to different medical schools in foreign countries—frightening the American students with newfangled regulations. It is

paradoxical to note that five Canadian provinces have passed specific legislation to allow graduates from the Autonomous Guadalajara Medical School to intern in their hospitals without taking the ECFMG examinations.

During my stay here, physician representatives from hospitals in Ohio, Michigan, and California have been interviewing students in the graduating class as prospective candidates for internships in their respective hospitals. They want bi-lingual, (Spanish and English) interns. Legislation has been introduced in several states to allow Guadalajara graduates to intern in their hospitals without ECFMG examinations. These alumni should be allowed to return to the United States where bi-lingual interns are so badly needed, especially in the metropolitan areas which have a large Spanishspeaking population. Communication between patients and interns and between staff and foreign-born interns is presently poor. This can be remedied by filling these positions with U. S. students and graduates from the Autonomous Guadalajara Medical School.

I have visited medical schools in the Soviet Union, India, Pakistan, Malaya, Iran, Ghana, Nigeria, Philippines and many other Asian and European countries. The medical school in Guadalajara has a stronger faculty, a better equipped physical plant, more modern laboratories, better equipped dissection and animal research facilities, and a greater amount of floor space in its new library than any of the other schools I have visited in those countries. A panel of consultants from the University of Kansas, Southwestern Medical School, University of Houston, University of Texas, and the Organization of American States has been closely identified with the local University.

Outside support has been received from the Ford Foundation, the Carnegie Fund through the University of Texas, and the United States Department of State.

It seems ridiculous to punish United States citizens who graduate from foreign medical

schools by making them take multiple examinations for internship and licensure. If they take the National Boards or State Boards or the Flex examinations, this should be sufficient for qualification as a practicing physician.

On top of all their other problems (such as being away from home from four to seven years and having to deal with a foreign culture and a foreign language) along comes the ECFMG, holding a club over their heads. At long last, legislative bodies at both the national and state levels of our government are

doing something about this frustrating folly. They have expressed concern about such duplicative examination requirements and about the contributions that these graduates can supply to the shortage of physicians in the United States.

It is time to reappraise our position regarding American citizens who are studying abroad and give them the same courtesies, the same privileges, and the same consideration we give to American citizens who study medicine at home.

377 South Harrison Street

Study of the Children of the Mentally Ill

Study of a "child's-eye-view" of a psychotic parent is leading to deeper understanding both of the child's chances of developing normally and of the mechanics of mental illness.

Dr. E. James Anthony, Washington University, St. Louis, has been awarded a new grant from HEW's National Institute of Mental Health, Health Services, to continue his study. In his previous work, Dr. Anthony has found that children of the mentally ill have an increased probability of becoming disturbed themselves, with greater vulnerability to psychotic stresses at certain points in their development. Surprisingly, the study showed that the effects of having a parent who is seriously ill physically can have an equally upsetting impact on the children.

The ages during which children appear to be most vulnerable to the strain of having a sick parent are four to seven, nine to eleven, and fourteen to sixteen. However, when the illness is severe, any age child can be affected.

With regard to school achievement, Dr. Anthony has found that children of normal parents do best, and children of physically ill parents seem most handicapped. On the other hand, 5 to 15 per cent of the children

studied developed "supernormal" capacities for adaptation in response to the stress of having a mentally ill parent.

To date, 82 families with 311 children have been studied. Of these, 38 families had a psychotic parent, 22 had a physically disabled member, and 22 had well parents. The new \$70,317 grant will permit Dr. Anthony to expand his study to include an additional 28 families with 59 children, and brings to nearly \$500,000 the amount of Federal funds invested in the study.

In several of his publications, Dr. Anthony has pointed out that new institutional policies in mental hospitals are exposing an increasing number of children to the effects of incipient, ambulatory, relapsing psychosis. "Some mentally ill parents in apparent remission can cause serious family discord favorable to the development of mental illness in the children," he has cautioned.

One answer is for hospitals to set up preventive clinics to handle the problems of the family when a psychotic parent is admitted or discharged, according to the psychiatrist, who has set up such a clinic in St. Louis.



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Like most shibboleths, the phrase "peer review" often becomes meaningless with overuse. Here a concrete meaning is given to it.

Peer Review—As Seen by the Internist*

Emanuel Abraham, M.D., Asbury Park
President-Elect, New Jersey Society of Internal Medicine

If medical publishers were to treat peer review with the same flamboyance they reserve for the introduction of a new drug, I can imagine headlines in forth-coming issues of the *Medical Tribune* or *Medical World News*:

Peer Review—New Anti-Depressant for the Blues! or

Physicians Inject Quality into Health Care by Peer Review or

Hospitals Claim Peer Review Responsible for Declining Costs and Rising Efficiency

Introduced as a panacea, accompanied by the politicians' rhetoric and supported by much of organized medicine, peer review threatens to occupy the limelight as if it were a new miracle drug about to conquer the common cold. What is this new wonder drug, not yet banned by the FDA, that holds the promise of cure for all of medicine's social and economic ills? Let's examine the background of this economic steroid, before it masks the defects it sets out to cure.

Medical review has been with us in many shapes and forms. In medical school, physical examinations and histories were reviewed by the assistant resident; as interns, by the chief resident; as residents, by the attending. It seemed as if "Big Brother" was always watching. If one doctor palpated a mass or heard a murmur, he was checked voluntarily, or involuntarily, by another. As part of our educational progression, we relied on our peers or were cross-checked by them.

Licensure and certification must be considered a form of peer review which, until recently, was thought to be the ultimate in

educational achievement. Now we recognize that recurrent examination of the medical practitioners' knowledge may be a necessity, if we are to judge continuing competence.

Can we forget hospital committees? Some of them have been performing peer review with varying degrees of success for many years: tissue committees, credential committees, medical records committees, medical audit committees, conservation of hospital bed committees, mortality conferences, and more recently utilization committees. Some of these bring a smile to your face because only you know their effectiveness (or lack thereof) in your own situation. To whom are these committees responsible? Are they diligent? Do they meet their responsibility? Or do they only cover up existing defects? Are they doing a job or merely satisfying the requirements for accreditation?

Within local medical societies there have been elementary forms of peer review for many years. These include insurance review, medical defense committees, and grievance or judicial committees. Do they protect the claimant or do they whitewash fellow physicians? Blue Plans and Medicare have review programs—not truly "peer."

For more than a decade, the Council on Medical Services of the AMA and its Committee on Health Care Financing have recognized the need for the establishment of professional review activities. Initially, this interest was generated by concern over the continuing increase in the costs of health care—"In accepting a responsibility for professional review activities the medical profession has

*Delivered at the 14th Annual Meeting of the New Jersey Society of Internal Medicine May 17, 1971 Atlantic City.

demonstrated its awareness of the need to conserve the patient's health-care dollar, educate and inform the profession in the economics of health care, assure appropriate use of health care personnel and facilities, and maintain a high standard of medical practice."

Now, that's a large order and had it been undertaken and operated efficiently, our subject for discussion might be different today.

Why do we need peer review? At the Medicare Health Insurance Advisory Council the following statement was presented:

"In order to provide an acceptable level of quality for the services rendered under Part B of Medicare, consideration should be given to establishing standards to govern the rendering of services by physicians, analogous to, but necessarily quite different in application from, the standards now established for most other providers of health care under Medicare. *The need for broad standards for physicians' services is predicated upon the right and responsibility of the government to have assurance of the acceptable quality of all services for which it provides reimbursement.* Precedents which have been set in government and non-government programs, and published studies, which point out the wide variability in quality of medical care, indicate the need.

"Thus, the standards of eligibility for physicians would be a 'preventive' measure to keep some physicians from *ever* rendering certain medical services under the Medicare program. This differs from the *post facto* stopping of abusers of the Medicare program. The latter may involve a few physicians, those who are grossly abusing the program. The former could potentially involve the future participation of many of the practicing U.S. physicians in the rendering of certain medical services under the Medicare program."

The answer to "why" is:

- (1) The Government must be assured that it is getting its money's worth.
- (2) The public must be assured that it's getting the quality of care it expects.
- (3) If the medical profession is to be blamed for rising costs of health care, then we should be permitted the right to supervise that area that we know best.
- (4) Allegations about the quality of practice find their way into the court rooms and

escalate the cost of practice. Medicine must demonstrate that we can and will review care so that delivery of health care will equal the promise.

So much for background—let's look at peer review today and begin with definitions:

PEER—One's equal.

REVIEW—To go over or examine again; look at or study again.

AMA—"Broadly-based state or county medical society organized committees, as opposed to utilization committees most commonly used to denote hospital-based committees under the direction of the hospital staff and limited to consideration of cases served by that specific institution."

CLAIMS REVIEW—Review of individual charges submitted for payment.

UTILIZATION REVIEW—Study of the frequency of charges or services to determine patterns of service or charges.

MEDICAL AUDIT—Analysis or audit of the medical care given a particular patient at a particular time in a particular setting, implying a retrospective review of records to determine if the essentials of care are documented. This mechanism may include a value judgment as to the quality of care given.

Let's put it all together and define:

PEER REVIEW—A review of the quality of care provided a patient by a practicing physician of comparable training and experience who will check for documentation of medical care (medical audit), diagnostic steps used, conclusions reached, therapy given, appropriateness of review, and reasonableness of charges. (Peer review then becomes synonymous with quality.)

How Does it Work?

The answers come from the experience of others throughout the country such as the foundations in California that have a seventeen-year history of success; from the experiences of state medical societies, as in Minnesota with nine years experience; and from the experience of third party payers and government agencies. Hopefully, peer review committees should be formed under the aegis of organized medicine. Although ultimate judgments must be made locally, state and county medical societies should form parent committees.

The Peer Review Committee must be composed of knowledgeable physicians distributed among the major specialties. Consultants should be available from the less common specialties. Advisory assistance from insurers or Blue Plans with expertise in special areas can be used at all meetings. Meetings should be held at regular and stated times. Minutes must be kept.

Who initiates peer review? The stimulus for review could emanate from any of the three parties involved in fee determination: *the patient, the physician, or the third party*. As review mechanisms have developed, the third party has been the one who most frequently initiates the review, primarily because the insurer is more highly organized to uncover possible deviations from the norm. This has been particularly true of problems *related to fees* and is currently true of problems *related to frequency of services*, both of which are identified by the insurer's computers.

On the other hand, problems related to quality of health care are difficult to program. It is probable that analysis and judgment of such problems will need to emanate from organized medicine.

The patient usually will not initiate peer review, except in certain cost situations or in certain quality questions where gross impro-

priety (and malpractice) allegations arise. Examples are the "shot doctor," the "travel doctor," and the "volume doctor."

Peer review exists to investigate deviations from the norm and to offer judgments on the propriety of fees, or quality of care rendered. It should, therefore, refer fraud, malfeasance, or other illegal activities to licensing boards, judicial committees, and other appropriate tribunals.

The committee's power is, at the least, advisory and consultative. In some instances, the decisions may be binding on either third parties, the physician provider, or both.

The ultimate goal of improving the quality of medical care is achieved by its influence on physicians, its emphasis on education, and the willingness of third parties to cooperate with a group of physicians who are dedicated to honesty and integrity, for they must be willing to sit in judgment of their fellows.

The cost of such peer review programs should be shared by medicine, the federal government, health insurers, and the public. All records and materials should be the property of the Peer Review Committee and should be confidential. Disclosures of information may be made solely to carry out the peer review process. The members of the committee, its employees, advisory committees, counsel, and so on, should not be criminally or civilly liable for participation in peer review.

What Should New Jersey Do?

The New Jersey Society of Internal Medicine stands ready to join forces with organized medicine, Blue Shield, Prudential, and any agency to establish appropriate peer review committees. We should leave today's meeting motivated to establish proper peer review mechanisms before we are reviewed by bureaucrats under federal statute. We should join forces and educate our physician friends at home that the survival of quality medical

care is dependent upon their acceptance of peer review, since it is organized medicine's answer to critics regarding quality and cost control.

Summary

- (1) Peer review is synonymous with quality.
- (2) Peer review is accomplished by a fellow practicing physician with comparable training in the same field of medicine and includes claims review, medical audit, over-utilization, under-utilization, and quality control.
- (3) The role of peer review should be the appraisal of the total spectrum of medical care.
- (4) Objectives of peer review are to educate all parties involved in medical care, ultimately improving care, and affecting costs and utilization.
- (5) Organized medicine must join forces *now* on local, state, and national levels to establish peer review mechanisms or the vacuum will be filled by governmental bureaucrats.

Military Medical School Opposed

The AMA has opposed establishment of a military medical school. Testifying before the House Armed Services Committee, Bland W. Cannon, M.D., of the AMA's Council of Medical Education, said:

"... We emphasize that our concern is that the men and women in our uniformed services should receive nothing less than the best in medical care. There is no reason why they should not continue to receive care from physicians trained in a medical education system which has proved itself to be unexcelled. We support an expansion and greater utilization of this system rather than the development of a new and different kind of institution..."

"The AMA believes it is vital that the number of physicians in the uniformed services be adequate to enable them to carry out their missions and that those physicians be thoroughly trained and competent in order that those serving our country in the uniformed services might receive the best possible medical care. However, it is doubtful that these objectives can best be realized through establishment of a separate uniformed forces medical school specifically to train physicians for the uniformed services in which all, or a

significant portion, of the physicians serving in these forces would receive their medical training. The armed forces should take full advantage of the resources and facilities of the existing medical schools of the United States in training their medical manpower, and such training should not be restricted in any degree to a single school established for that purpose."

The AMA supported provisions in the legislation for helping medical students with scholarships with a requirement that they serve on active duty for a number of years after completion of training.

The AMA says that through affiliation agreements between existing medical schools and the armed services, "larger numbers of physicians could be produced for the uniformed services at substantially lower costs, in a shorter period of time, and with the quality of the medical education assured."

Despite the opposition of the AMA and the Association of American Medical Colleges the committee unanimously approved the bill. The legislation would authorize a medical student scholarship program of \$210 million over the next five years. The military medical school would be built in the Washington area.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

A regular meeting of the Board of Trustees was held on October 17, 1971, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Smallpox Vaccination . . . Voted to support the following recommendation from the United States Public Health Advisory Committee and directed that the New Jersey State Department of Health be so informed:

Because of the rapidly declining incidence of smallpox in the world and the vastly reduced risk of its being imported into the United States, health officials in the United States should consider the discontinuation of compulsory measures as they relate to routine smallpox vaccination.

Amphetamines—Union County Resolution . . . Received as informative the following resolution on the subject of amphetamines which was adopted by the Union County Medical Society on September 15, 1971:

RESOLVED, that the Union County Medical Society recommends and urges its members to limit the prescription of amphetamines and similar drugs except for the treatment of Narcolepsy, the Hyperkinetic Child Syndrome, and the first few weeks of Weight Control Programs.

IRS Regulations Relative to Non-Related Income of Non-profit, Tax Exempt Organizations . . . Received the following report from Legal Counsel concerning new IRS regulations at they may affect MSNJ:

All tax exempt organizations under the provisions of Section 501 of the Internal Revenue Code are obliged by Section 511 of that Code to report and pay tax upon income derived from any unrelated trade or business (includes periodicals). That income is the gross income from any unrelated trade or business regularly carried on by the exempt organization, less the deductions which are directly connected with the carrying on of that trade or business.

Under existing regulations, gross income of *The Journal* includes money received from sale of advertising, subscription fees (\$2.50) charged members of the Society and the \$5.00 subscription fee charged non-members. Up to this moment, our experience has been that after deducting costs of the Society for pro-

ducing *The Journal*, no taxes are due to the federal government. In this connection, it is pointed out that we have not had occasion to utilize all allowable deductions to arrive at that result.

The proposed regulations do not change existing regulations regarding deduction of costs of publication. However, they do impose a formula for determining gross income from exempt organization periodicals which, while not presently affecting our Society, will, if promulgated, establish a base upon which onerous regulations could be developed requiring our paying a tax. However, all tax regulations are precedents for increased taxes at a later date. From a legal standpoint, the sole question is whether the new formulae for determining the income attributable to exempt organizations' periodicals are reasonable. I believe they are reasonable.

Of the new formulae, only one is of major concern—"Allocation of membership receipts to subscription income." The formula for this allocation is based upon three factors: (a) Subscription price charged to non-members (sales to non-members are given higher weight than those to members if the sales to non-members constitute 20 per cent or more of the total circulation); (b) Subscription price to members (applicable only if membership receipts from a significant percentage of members of an exempt organization are less than those received from the other members because such significant percentage of members do not receive the periodical); (c) subscription price of comparable periodicals of taxable organizations (none of which I am familiar).

Of the above factors, only (a) would be applicable to our Society. Our sales to non-members (\$5.00) represents but 8 per cent of the total circulation income, therefore our subscription fee of \$2.50 to members is not subject to question by the proposed IRS regulations. The point I make here, as indicated above, is that by change of formula in subsequent regulations, it could be!

In addition to the above, the Business Manager contacted Mr. Fleming, field auditor of IRS, who worked on the Exempt Organization Business Income Tax Return (990-T form) of the Society in May of 1970. Mr. Fleming advised that it was his understanding the major effect was to impose the same restrictions related to "unrelated business taxable income" on labor unions as are now imposed upon charitable organizations. Presently "unrelated business income" of labor unions—IRS 501 (c) (7) and 512 (a) (3)—is governed by special regulation. A review of the proposed regulation and the Internal Revenue Code sections cited above support the comment of Mr. Fleming.

Emergency Departments of New Jersey Hospitals . . . Approved the following recommendation (amended by the Board) from the Committee on Emergency Medical Care:

That the Board of Trustees send copies of the "Survey of Emergency Departments of Hospitals in New

Jersey" (condensed below) to the U.S. Department of Transportation, the Governor of New Jersey, the State Commissioner of Health, the State Commissioner of Transportation, and Henry C. Huntley, M.D., Director of the Division of Emergency Health Service of the U.S. Public Health Service.

Survey of Emergency Department of New Jersey Hospitals

(The survey was conducted by The Medical Society of New Jersey in cooperation with the Division of Emergency Health Services, USPHS. The purpose was to evaluate and stimulate emergency departments to function effectively at all times. Survey forms went to 141 hospital administrators and 114 replies were received, from which these generalizations were elicited:

1. Most hospitals answering were private or community non-profit, not church-related.
2. Eighty-four per cent have an emergency room or department.
3. Few hospitals have 24-hour physician staffing; more than half have either registered or lp nurses on a 24-hour basis; a number use non-physician personnel on call from other departments; about half have clerical personnel to assist with administrative procedures; fifty per cent of emergency departments are under direction of medical advisory committees.
4. Less than half have sufficient equipment and supplies, including inhalation devices, cardiac equipment, and poison control carts.
5. Seventy per cent of hospitals lack radio communication among themselves; ninety per cent cannot communicate by radio with ambulances.
6. About half could function adequately if sufficient personnel were available; most hospitals continue to use emergency departments as an outpatient facility.
7. Emergency department is entry point to health care for many. This is directly related to growth of specialization and decline in number of general practitioners; reluctance of physicians to make house calls; movement of large numbers of people from one area to another; increase in population; and use of hospital as preferred site for treatment of trauma and non-acute illness.
8. Emergency departments have not been given proper status in relation to other departments; emergency department must be separate from outpatient department; proper equipment and trained personnel must be provided to minimize transfer of patients; general public must be educated to capabilities of emergency departments.

Training Program for Medical Technicians . . . Approved the following recommendation from the Committee on Emergency Medical Care:

That all medical ambulance attendants in New Jersey (must) complete the emergency ambulance training program—as outlined and recommended by the U. S. Department of Transportation's basic training pro-

gram for Emergency Medical Technicians-Ambulance or its equivalent—and that qualified instructors for this program be physicians, who may be assisted if necessary by trained allied medical personnel.

Emergency Department Training Program . . . Approved the following recommendation from the Committee on Emergency Medical Care:

That all interns, residents, and attending staff be given appropriate training in emergency medical care of all types and, further, that emergency medical care be incorporated in the academic and clinical training of all medical students in New Jersey medical schools.

Disaster Inventory Program . . . Approved the following recommendation from the Committee on Emergency Medical Care:

That The Medical Society of New Jersey send a letter to all general (medical and surgical) hospitals in the State of New Jersey urging them to subscribe to the Hospital Disaster Inventory Program.

Drug Abuse . . . Approved the following amended (by the Board) resolution from the Committee on Emergency Medical Care:

That The Medical Society of New Jersey issue a policy statement declaring that physicians should carefully scrutinize the prescribing of all drugs having potential for abuse.

Joint Conference of Presidents and Presidents-Elect . . . Met with members of the Conference of County Presidents and Presidents-Elect, representing 19 counties, and discussed the following items: (1) statewide automated bookkeeping system; (2) procedures affecting legislation; (3) progress on Resolution #24 which is concerned with the introduction of legislation relative to professional liability; (4) status of S-2275, "to prescribe requirements to which all prescriptions for controlled dangerous substances must comply under supervision of the Commissioner of Health;" (5) status of A-2500, "to provide for increased health manpower by giving Board of Medical Examiners authority to develop and approve training programs for syniatrists and to permit syniatrists to perform certain medical services under supervision of licensed physician" (MSNJ has taken position of approved); (6) licensure requirements of U.S. citizens attending foreign medical schools; (7) peer review; (8) membership of osteopathic physicians;

(9) professional liability insurance; (10) medical student loans; (11) private health diagnostic clinics (12) closer communication between MSNJ and general membership re Medicare and Medicaid commitments; (13) guidelines for conduct of medical practice; and (14) S-752, "to provide that blood, blood plasma, or tissue or organs shall not be considered commodities subject to sale." Dr. Gustav L. Ibranyi of Essex County was chosen Chairman of the group for the spring and fall conferences in 1972.

AMA Delegates and Alternates. . . . Reaffirmed its policy position by which AMA Delegates are invited to attend Board meetings and are supplied with copies of the minutes thereof; amended that policy to include Alternate Delegates.

Trustees' Plaques . . . Agreed that members of the Board of Trustees should receive their plaques (as members of the Board) at the time of coming to the Board and not at the time of leaving.

Dangerous Drug Law*

Last year, the New Jersey Legislature, at the instance of the Cahill Administration, approved the first amendment to the State's narcotics laws in seven years—and the first thoroughgoing legislative review of narcotics law enforcement philosophy in the State's history—when it adopted the New Jersey Controlled Dangerous Substances Act of 1970. Among a host of significant provisions the act takes a first step toward recognizing in law that drug use is a social and medical problem, as well as a law enforcement problem. Evidence of this shift in philosophy can be seen clearly in the way that act and related legislation deals with physicians.

The Controlled Dangerous Substances Act became effective on January 17, 1971. Under its provisions, dangerous substances are classified into five schedules or categories based on their relative potential for abuse and their

current acceptance in medical use. The amount of control mandated by the act and the sanctions for violation vary accordingly—the penalties are most severe for violations which involve use of substances listed under Schedule I, and least severe involving substances listed in Schedule V.

The act also requires that all elements in the distribution chain—manufacturers, distributors, or dispensers of controlled dangerous substances—obtain an annual registration issued by the Department of Health through the newly reorganized Division of Narcotic and Drug Abuse Control. Further, a "dispenser" is defined to include professional practitioners who prescribe, administer, package, or deliver a controlled dangerous substance to an ultimate user. Such registrants are required to obtain a separate registration for each principal place of business or professional practice they maintain. They must keep records and inventories in conformance with both federal laws and the rules and regulations of the Commissioner of Health, and they must maintain effective controls against diversion of controlled dangerous substances into illicit channels. The Division of Narcotic and Drug Abuse Control began initial registration last July 1.

Also under the new act, mandatory minimum penalties for drug abusers have been removed in order to permit the courts appropriate flexibility in sentencing; at the same time penalties concerning sales and trafficking in dangerous substances have been toughened. New conditional discharge provisions give the courts appropriate discretion in certain cases to suspend proceedings against first offenders and impose a term of supervisory treatment, and then to dismiss the proceedings if the imposed conditions are met. Also, simplified early expungement procedures are made available to youthful offenders who have successfully completed probationary terms so they need not be saddled for life

*Reprinted from an editorial by George F. Kugler, Jr., Attorney General, State of New Jersey, which appeared in the Camden County Medical Society *Bulletin*, October 1971, Vol. 44, No. 1, pp. 5 and 16.

with criminal records. In short, the new act's attitude toward the young drug offender who is not involved in other crime is one which recognizes the medical and sociologic nature of his addiction and which attempts to deal with it appropriately through medical channels, rather than through the courts and jails.

Similarly, the new act changes requirements upon medical practitioners who come upon a drug abuser in their practice. Previously, physicians were required to report drug-dependent persons to the Superintendent of State Police. However, it has been the philosophy of the Cahill Administration, as expressed through the Legislature, that practitioners should be expected to provide professional treatment and not obliged to be arms of the police. Accordingly, practitioners now report such drug-dependent cases to the Department of Health, as they do with other public health problems. These reports are confidential and are not admissible in any criminal proceeding. However, they will assist significantly in implementing a second major product of the Administration's legislative attack on drug abuse—the Controlled Dangerous Substances Registry Act of 1970. Under this bill, the Division of Narcotic and Drug Abuse Control is charged with collecting appropriate data from physicians, dentists, veterinarians, hospitals, treatment facilities, public officials, and others in order to compile factual information concerning drug abuse and in order to establish a statewide controlled dangerous substances registry. These data will be computerized and analyzed and hopefully, will enable us to define the dimensions and the scope of our drug abuse problem, to evaluate and compare the effectiveness of various treatment methods, to improve planning of programs for treatment and control efforts, and to disseminate statistical information. This second law provides also for strict confidentiality of individual reports, permitting only prior offense information to be furnished to the courts and court-connected officials. The act also provides a civil immunity to the persons furnishing information or data to the registrant.

New Jersey's amended narcotics statutes, then, indicate our reliance on the physician in those areas for which he is best equipped to assist—that is, to help all of us understand the drug problem and also to control and, hopefully, to halt the flow of illicit narcotics. Meanwhile our new laws preserve the sanctity of his examination room and the confidentiality of the physician-patient relationship. Thus, the professional practitioner is provided with what I believe to be an appropriate role in the total attack on drug abuse—a role which takes into account his responsibility to his patient, to his profession, and to society.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Kin Siu Tam, M.D., 320 East North Avenue, Pittsburgh, Pennsylvania 15212. South China Medical College 1958. Hospital. Available July 1972.

Vilas R. Herekar, M.D., 37-20, Apt. 5P, 83rd Street, New York 11372. Grant 1964. Group or partnership. Available.

Bakula I. Desai, M.D., 40-39 Junction Boulevard, Corona, New York 11368. Baroda (India) 1965. Institution. Available.

CARDIOLOGY—H. Robert Silverstein, M.D., 3B Powell, Westover Air Force Base, Chicopee, Massachusetts 01022. Ohio State 1965. Board certified. Group or institution, administrative, teaching. Available.

CARDIO-THORACIC SURGERY—F. I. Ehrenstein, M.D., U. S. Naval Hospital Memphis, Millington, Tennessee 38053. Istanbul 1962. Board certified. Partnership, solo. Available March 1972.

GENERAL PRACTICE—Michael F. O'Connor, M.D., 15,520 Windmill Pointe Drive, Grosse Pointe Park, Michigan 48230. University College, Cork, Ireland 1970. Solo. Early 1972.

R. Jackson Dykes, M.D., Box 304, Allenwood 08720. Baylor 1967. Locum Tenens. Available January 1972.

INTERNAL MEDICINE—Nicholas A. Cannarozzi, M.D., 1 Hemlock Hill Road, Clinton, Connecticut 06413. Hahnemann 1965. Board eligible. Subspecialty, rheumatology. Association, partnership, or solo. Available July 1972.

Edward J. Feller, M.D., 4287-1 Wilmington Drive, Andrews AFB, Washington, D.C. 20331. State University of New York 1965. Board certified. Subspecialty Gastroenterology. Partnership, group, or hospital-based. Available, summer of 1972.

Yong Hak Park, M.D., 1130 Stadium Avenue, Bronx, New York 10465. Woo-Suk University, Seoul, Korea. Sub-specialty, cardiology. Board eligible. Hospital or group. Available January 1972.

David S. Rosenthal, M.D., 4 Woodland Street, Natick, Massachusetts 01760. NYU 1963. Sub-specialty, endocrinology and nuclear medicine. Board certified. Group or partnership. Available July 1972.

Robert Schnitzler, M.D., 11 Fillat Street, Staten Island, New York 10314. SUNY at Buffalo 1965. Board certified. Subspecialty, cardiology. Group or fulltime hospital. Available July 1972.

OBSTETRICS AND GYNECOLOGY—Teresita M. Gungon, M.D., 9316 Seaview Avenue, Brooklyn, New York 11236. Santo Tomas, 1961. Board eligible. Full-time hospital, group, or partnership. Available August 1971.

Vellore Bhupathy, M.D., 802 Gaston Avenue, Fairmont, West Virginia 26554. Bangalore (India) 1961. Board eligible. Group, partnership, institution, or solo. Available.

Shi-Han Oh, M.D., 13-C Concord Cove Apts., Havre De Grace, Maryland 21078. Seoul University (Korea) 1960. Board eligible. Group or partnership. Available January 1972.

OPHTHALMOLOGY—John H. Park, M.D., 711 South Gunderson Avenue, Oak Park, Illinois 60304. State University of New York 1966. Partnership or solo. Available January 1972.

Frank J. Grady, M.D., 4800 Fort Crockett Boulevard, Galveston, Texas 77550. Yale 1965. Board certified. Solo or join retiring ophthalmologist. Available March 1972.

ORTHOPEDIC SURGERY—Jalal Sadrieh, M.D., 430 East 67th Street, New York 10021. Pahlavi (Iran) 1962. Board eligible. Solo, partnership, or group. Available January 1972.

H. Vossoughi, M.D., 20 Hobart Street, Welch, West Virginia 21801. Tehran (Iran) 1961. Board eligible. Solo or partnership. Available.

PATHOLOGY—John S. Weinstein, M.D., 123 York Street, Apt. 11-D, New Haven, Connecticut, New Jersey College of Medicine 1966. Board eligible. Any type of practice. Available July 1972.

Joseph W. Placer, M.D., 130th Station Hospital, APO, New York 09102, New York Medical 1964. Board certified. Group, partnership, or institution. Available September 1972.

PEDIATRICS—Kalavathi Bhupathy, M.D., 802 Gaston Avenue, Fairmont, West Virginia 26554. Bangalore (India) 1961. Board certified. Group, partnership, clinic, or institution. Available.

Nevin Esenler, M.D., 601 Roxbury Court, Apt. 3, Oregon, Ohio 43616. Ankara (Turkey) 1956. Group or partnership. Available July 1972.

RADIOLOGY—R. D. Kattan, M.D., 14-A Pitman Street, Somerville, Massachusetts 02143. Baghdad 1955. Board certified. Institution, hospital, partnership, or group. Available.

SURGERY—Sun Jiang Guo, M.D., Western Massachusetts Hospital, 91 East Mountain Road, Westfield, Massachusetts 01085. Taiwan University 1964. Board eligible. Associate or hospital-based. Available July 1972.

Charles P. Carroll, M.D., 5011 Caryn Court, Apt. 303, Alexandria, Virginia 22312. New York University 1965. Board eligible. Available July 1972.

Krishna K. Vadlamudi, M.D., 350 West 51st Street, Apt. 11-B, New York, 10019. Wuerzburg (Germany) 1965. Board eligible. Group, partnership, or solo. Available July 1972.

Mohammad Zafrullah, M.D., 600 West End Avenue, New York 10024. King Edward (Pakistan) 1960. Group, partnership, solo, or hospital. Available.

P. Shinghal, M.D., 115 Town Square Drive, Newport News, Virginia 23607. Indore Medical (India) 1961. Board eligible. Group or partnership. Available.

UROLOGY—A. Turhan Ilkay, M.D., 22 Fairhaven Boulevard, Woodbury, New York 11797 Istanbul (Turkey) 1951. Board eligible. Any type of practice. Available.

VASCULAR SURGERY—Norman M. Finkelstein, M.D., 7530 Brompton Road, Apt. 795, Houston, Texas 77025. Columbia 1965. Board eligible. Group or partnership. Available July 1972.

Patronize Our Advertisers

ATTENTION COMPONENT SOCIETIES Please Note!

The 206th Annual Meeting of MSNJ will be held **May 6 to 9, 1972**. Please schedule your county meeting for election of delegates and alternate delegates so that the names can be forwarded to the Executive Offices no later than **April 1, 1972**.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during September and October 1971:

	1970 September	1971 September
Aseptic meningitis	68	44
Primary encephalitis	2	1
Hepatitis: Total	277	491
Infectious	220	342
Serum	57	149
Malaria: Total	7	12
Military	4	9
Civilian	3	3
Meningococcal meningitis: Total	5	2
Military	2	1
Civilian	3	1
Mumps	30	16
German measles	1	5
Measles	7	6
Salmonella	66	120
Shigella	3	56

	1971 October	1970 October
Aseptic meningitis	33	56
Post-infectious encephalitis	1	
Hepatitis: Total	445	427
Infectious	315	334
Serum	130	93
Malaria: Total	16	4
Military	11	4
Civilian	5	
Meningococcal meningitis	11	8
Mumps	19	72
German measles	10	12
Measles	4	4
Salmonella	130	76
Shigella	40	39

Combined Rubella and Measles Vaccine

A new vaccine, combining live, attenuated strains of rubella virus and measles virus, has recently been licensed for use. Field trials (prior to the licensure of this vaccine) indicate that antibody responses to both measles and rubella in this combined vaccine were comparable to those achieved by administering each vaccine separately. In addition there was no evidence that adverse reactions were more common or more severe with the combined vaccine than with the use of vaccines containing either one of the two viral antigens.

This combined vaccine, like other biologic materials supplied by the New Jersey State

Department of Health, is available free of charge to physicians for use for patients who need to be spared the cost of the vaccines. These vaccines are distributed through our local biologic distributing stations. Monovalent rubella and measles vaccine will continue to be available for children who have received one, but not the other, of the monovalent vaccines or who have had a history of measles.

The State Department of Health will be using the combined vaccine whenever possible in the ongoing programs of mass vaccination of preschool children. The combined vaccine will also be largely used in the Child Health Conferences. Hopefully, the use of the combined vaccine will lift the proportion of children immunized in New Jersey against both measles and rubella by obviating a second trip by the child to either a physician's office or a vaccination clinic.

Should you have any questions about the use of this vaccine, please call us at (609) 292-5635. In addition, we are eager to receive reports about outbreaks of either measles or rubella. The incidences of measles has been increasing in New Jersey during the past several years. Last year, several outbreaks occurred in junior and senior high schools. Outbreaks of measles can usually be rapidly abated by canvassing the pupils, determining who is susceptible to measles, and vaccinating those children. Thus, it is important to our immunization efforts that cases of measles and rubella be reported promptly.

Illness Caused by Air Pollution

In mid-September eight junior high school football players were hospitalized with what was initially thought to be pesticide poisoning. Twenty others were seen at an emergency room and released. At this particular school, aerial spraying for mosquito control had been done on the day the boys became ill. The product used was a mild organophosphate. The predominant symptom was substernal chest pain aggravated by deep inspiration. Many of the patients also complained of

burning in the back of the throat and others had burning eyes and nausea. The symptoms cleared within 24 hours in those eight players who were hospitalized.

Interviews with the pilot of the helicopter indicated that the spraying had been done in the woods in back of the school but that no spraying had been done on the school grounds or near the football field. Physical inspection of the sites sprayed and the football field, as well as analysis of pesticides levels in soil samples for these two sites, did not indicate that any spraying had been done on the football field itself. Cholinesterase levels in the eight hospitalized patients were normal.

The lack of evidence implicating pesticides as a cause of the illness led to a telephone survey of 50 schools in the surrounding area. Football players at ten additional schools had suffered similar, but seemingly milder symptoms, on the same day as those players in the index town. In each instance, symptoms occurred an hour or so after football practice had begun and only players undergoing moderate to severe physical stress became ill.

Meteorologic data for the day on which the illness had occurred, indicated that relatively stagnant air was located over northern New Jersey. The oxidant levels in Newark and Bayonne for that day were .09 p.p.m. Similar kinds of symptoms have been seen in football players in California at oxidant levels in this range.

It has been concluded that the illness seen in these football players was probably due to air pollutants. The day following the onset of the illness, wind conditions over northern New Jersey changed and air pollutants moved out of the area.

This incident shows the need for additional programs of the health related effects of air pollution. The various State agencies concerned with the environment and well-being of citizens in New Jersey are currently developing guideline procedures in this area.

Specifically, better ways of detecting disease caused by air pollution, levels of air pollution which can be expected to cause illness in particular segments of the population, and general recommendations for averting similar episodes in the future are being developed.

206th Annual Meeting

May 6-9, 1972

Chalfonte-Haddon Hall

Atlantic City

The Names of Our Medical-Dental Schools

New names for the three schools of the College of Medicine and Dentistry of New Jersey have been announced by John K. Kittredge, Chairman of the College's Board of Trustees.

The College's Dental School at 201 Cornelison Avenue, Jersey City, is now College of Medicine and Dentistry of New Jersey—New Jersey Dental School. Dean of the School is Ian C. Bennett, D.D.S., M.S.D.

The Newark Medical School at 100 Bergen Street, Newark, is now College of Medicine and Dentistry of New Jersey—New Jersey Medical School. Dean of the School is Rulon W. Rawson, M.D.

The School of Medicine at Piscataway, P.O. Box 2100, New Brunswick, is now College of Medicine and Dentistry of New Jersey—Rutgers Medical School. Dean of the School is James W. MacKenzie, M.D.

President of the College of Medicine and Dentistry of New Jersey is Stanley S. Bergen, Jr., M.D.

ANNOUNCEMENTS

Clinical Application of Basic Sciences

The Burlington County Memorial Hospital lists the following in their "Clinical Application of Basic Sciences" series for January 1972—all sessions convene at 3:30 p.m. and are held in the T. J. Summey Building of the Hospital.

January 6 Viral Hepatitis
January 13 Cardiomyopathy
January 20 Mild Hypertension
January 27 Orthostatic Hypotension

One and a half credits are given by AAGP for each session attended. For further information, please contact the Department of Medical Education, Burlington County Memorial Hospital (175 Madison Avenue, Mount Holly).

Ophthalmologic Conference

The 24th Annual Clinical Conference of the Wills Eye Hospital will be held on February 3 to 5, 1972, at the Bellevue-Stratford Hotel in Philadelphia. The Bedell Lecture will be given by Dr. Lorenz E. Zimmerman, Washington, D.C. The program includes Symposia on "Failures in Cataract Surgery and How to Avoid Them" and on "Retinal Vascular Occlusive Disease," plus Workshops on Plastic Surgery, Retinal Diseases, Refraction, Motility, Anesthesia, and Neurology. Inquiries should be addressed to Dr. Robert D. Mulberger, Clinical Conference Committee, Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia, Pennsylvania 19130.

Cardiorespiratory Care

"Modern Concepts in Acute and Chronic Cardiorespiratory Care—Newborn, Adult," a four-day graduate course, will be presented in Steamboat Springs, Colorado, February 28 to March 2, 1972. This program has been developed jointly by the American College of

Chest Physicians, University of Colorado Medical Center, and the Cystic Fibrosis Foundation. This program is being presented in a resort area to create a relaxed and informal atmosphere. It will provide physicians with up-to-date information on pulmonary problems in newborns and adults. Specifically, the program will present updated diagnostic and therapeutic information in such problems as RDS, reactive airway disease, and chronic obstructive problems. Didactic lectures, slides, movies, and practical sessions with actual equipment will be used to present the material. Specific subjects to be covered by the faculty include: shock in the newborn, individual audiovisual aids, assisted ventilation in asthma, cystic fibrosis and chronic obstructive airway diseases in children and adults, congenital lung disease, oxygen transport, blood gases, resuscitation, intensive care, hospital and home care, as well as inhalation therapy and related equipment. Time has been allotted for small group work and practice sessions. Registration fee is \$100 for ACCP members; \$125 for non-members, \$50 for residents. For further information, write to the Department of Continuing Education, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

Medico-Legal Course

In conjunction with its medical and law schools, the University of Miami announces a four-day seminar in medical malpractice to take place March 1 to 4, 1972, at the Americana in Bal Harbour, Florida. This will be useful to physicians and to hospital administrators and is described as "an in-depth introduction to the legal rights and duties of physicians, taught by practicing lawyers in a non-adversary, factual, legal, and practical way." For further details, write to Medical-Legal Institute, University Law Center, P.O. Box 8087, Coral Gables, Florida 33124.

Plastic Surgery Congress in Europe and Ethiopia

The Fourth Congress on Ophthalmic and Otolgic Plastic Surgery will be held in Italy, Ethiopia, and the Greek Islands, during March 1972. The trans-Atlantic flight will be *via* a Sabena plane. First-class hotels and English-speaking guides and tour escorts are provided. For more information, write to Ralph L. Dicker, M.D., 395 West Blackwell Street, Dover, New Jersey 07801.

Maxillofacial Trauma

March 13 to 16, 1972 are the dates for the colloquium on maxillofacial trauma at the Department of Otolaryngology and Maxillofacial Surgery, University of Cincinnati Medical Center, Cincinnati, Ohio. It is sponsored

by the American Academy of Facial Plastic and Reconstructive Surgery. This is a practical workshop in the treatment of maxillofacial fractures, including dissection of laboratory specimens. Tuition fee is \$400. For details write to Miss Debby Adkins, CONMED, Room 114, University of Cincinnati College of Medicine, Cincinnati, Ohio 45219.

Well-Trained Psychiatrists Available

The Menninger Foundation announces that several residents, who will finish their training in July 1972, will be available for placement at that time in both public and private agencies and institutions. If interested, write to the President, Fellows Association, Menninger School of Psychiatry, 2601 East 25th Street, Topeka, Kansas 66605.

SCIENTIFIC EXHIBIT APPLICATION FOR 1972 ANNUAL MEETING DUE JANUARY 3, 1972

See page 951 November *Journal*, or contact Mrs. Walton,
Convention Manager, MSNJ, P.O. Box 904, Trenton

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This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

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Mount Holly
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| 8 | Academy of Medicine of New Jersey
Saint Michael's Medical Center
Newark
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Bloomfield
Section on Dermatology |
| 8 | Academy of Medicine of New Jersey
Bergen Pines Hospital
Paramus
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Secaucus
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Mount Holly
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|--|--|

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terene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Practicing physicians can expect to be confronted at almost any time with a medical crisis related to the misuse of psychoactive drug substances. Increasing numbers of people are misusing these drugs and a dramatic increase in the number of drug-related medical crises has been noted during the past several years.

Although much information on this subject has been disseminated, the need for practical advice on basic clinical management of these crises has become greater.

Three physicians, each of whom has had extensive practical experience in dealing with drug abuse problems, have created a series of three-minute audiotapes detailing basic medical approaches to the most frequently encountered drug abuse crises.

Dr. David E. Smith is Director of the Haight-Ashbury Medical Clinic in San Francisco, California, and Assistant Clinical Professor of Toxicology, University of California Medical Center at San Francisco.

Dr. William Abruzzi was Medical Director of both the Woodstock and Powder Ridge Rock Festivals and is currently the College Physician, State University of New York at New Paltz, New York.

Dr. Edward C. Senay is the Director of Clinical Research for the Illinois Drug Abuse Program and Associate Professor of Psychiatry at the University of Chicago School of Medicine, Chicago, Illinois.

Their taped discussions are on automatic telephone equipment for utilization at all times. The opinions given regarding treatment modalities are those of the physician speaking.

Amphetamines	Dr. David E. Smith
Hallucinogens	Dr. William Abruzzi
Opiates	Dr. Edward C. Senay

For further information, contact your Roche Representative or write:

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OBITUARIES

Dr. Morris R. Berlin

A well-known Essex County family physician, Morris R. Berlin, M.D., died on September 6, 1971. Born in 1914, he earned his M.D. degree at Bellevue in 1939. Three years later, he entered the Army of the United States and served during World War II as a captain in the medical corps. He was affiliated with the Martland Medical Center in Newark, the Beth Israel Medical Center in that city, the Irvington General Hospital, and the Clara Maass Hospital in Belleville.

Dr. Richard T. Buckley, Jr.

One of south Jersey's leading general practitioners, Richard T. Buckley, Jr., M.D., died on October 2, 1971, at the age of 68. Dr. Buckley was in the class of 1927 at the Medical School of the University of Pennsylvania. He was active in the American Academy of General Practice and was on the staff of the Burlington Memorial Hospital in Mount Holly. Dr. Buckley was a resident of Maple Shade and a member of our Burlington County Medical Society.

Dr. Louis M. Bull

One of Essex County's senior obstetricians and gynecologists, Louis M. Bull, M.D., died on September 27, 1971, at the age of 77. During his active practice, from 1920 to 1964, he was on the staffs of St. Barnabas Medical Center in Livingston and the Irvington General Hospital. He was a Bellevue graduate, class of 1919. Dr. Bull was living in Maplewood at the time of his death.

Dr. Alfred M. Elwell

Word has just been received from North Carolina of the death there on September 24, 1971, of Alfred M. Elwell, M.D. Born in 1916, he was only 55 years old at the time of his death. He was a 1941 graduate of the medical school at the University of Pennsyl-

vania and practiced in Moorestown until 1968, when he moved to Brevard, North Carolina. However, he retained his membership in our Burlington County Medical Society. Dr. Elwell was a general practitioner on the staff of the Transylvania Community Hospital in Brevard. While in our state, he was identified with the Burlington County Memorial Hospital at Mount Holly and with the Zurbrugg Hospital in Riverside.

Dr. Joseph M. Fitzgerald

Born in 1910, Joseph M. Fitzgerald, M.D., a member of our Cape May County Society, died on August 17, 1971. He was graduated in 1936 from Columbia University's College of Physicians and Surgeons and served for a while as Assistant Professor of Cardiology at the University of Alabama. Prior to that service he practiced in Red Bank, and on return to New Jersey in 1965 he became affiliated with the Tomlin Memorial Hospital in Cape May Court House.

Dr. Joseph G. Gershman

Born in 1907, Joseph G. Gershman, M.D., died on October 6, 1971. He was a prominent Bergen County physiatrist, active in the work of the American Academy of Physical Medicine. He received his M.D. in 1930 at the University of Michigan. Dr. Gershman was the attending physiatrist at Englewood Hospital.

Dr. Nathan H. Greenberg

A 1934 alumnus of the University of Bristol (in Great Britain), Nathan H. Greenberg, M.D., was a general practitioner with special interest in geriatrics. He was a Fellow of the New Jersey Academy of Medicine, and had practiced in Essex County since 1935. He was 64 years old at the time of his death on September 25, 1971.

Dr. William A. Jarrett

Word has just been received of the death on April 12, 1971, of William A. Jarrett, M.D., at

Avoca, New York. Dr. Jarrett was a member of our Middlesex County Medical Society, a 1934 graduate of Harvard Medical School. He had been director of laboratories at St. Peter's Hospital in New Brunswick. He was board-certified in pathology, an officer of the medical corps of the Army of the United States during World War II, and a Fellow of the College of American Pathologists. Dr. Jarrett was 63 years old at the time of his death.

Dr. Harry A. Lowenstein

Long active in the field of industrial and traumatic medicine, Harry A. Lowenstein, M.D., died on September 27, 1971, at the age of 80. He received his M.D. at Bellevue in 1913 and served the people of the Newark area from 1914 until his retirement in 1965. During his days of active practice, he was on the staffs of Beth Israel and Presbyterian Hospitals in Newark.

Dr. Harold R. Scott

Some years ago, *Suburban Life* accoladed Harold R. Scott, M.D., as one of the truly distinguished citizens of the Orange area. Born in 1902, Dr. Scott died on September 28, 1971, at the age of 69. He was a 1930 alumnus of the Medical School at Howard University. A general practitioner, he was on the staffs of both Orange Memorial and St. Barnabas Medical Centers. He was on the board of directors of Prospect House, an East Orange

day center for persons with emotional illnesses. He was active in the Crippled Children's Camp Association, a trustee of the United Community Services of Orange and Maplewood, and on the board of the YMCA of the Oranges.

Dr. Arthur S. Thurm

His many friends were shocked on October 9, 1971, when Arthur S. Thurm, M.D., was found dead in bed at the untimely age of 59. Dr. Thurm was a well-known central New Jersey orthopedist, a 1936 graduate of the Medical School of Georgetown University. He was board certified in his chosen specialty, chief of the orthopedic service at St. Francis Hospital in Trenton, and consulting orthopedic surgeon to the Princeton Hospital. He was a member of our Mercer County Medical Society.

Dr. Harold F. Tidwell

Word has come from Lake Worth, Florida, of the death there on September 22, 1971, of Harold F. Tidwell, M.D. Dr. Tidwell was a pioneer pediatrician in the Hudson County area. Born in 1891, he was graduated from Vanderbilt's Medical School in 1914. He was for many years on the pediatric staffs of both Christ Hospital and the Margaret Hague Hospital in Jersey City and was active in the affairs of the American Academy of Pediatrics. Dr. Tidwell retired to Florida in 1965.

The Old Helping Hand Organization

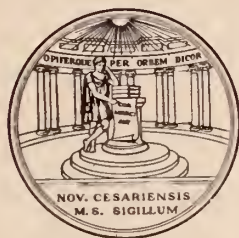
Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance

to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

For details, write to the Society at P.O. Box 95, Belleville, New Jersey.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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1971

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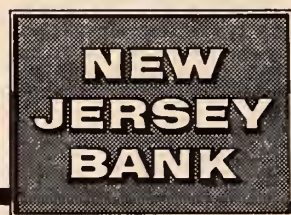
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- Fred G. Schwing, M.D., Board Certified Physiatrist, Director of Rehabilitation Dept.
- Ruth Rahilly, R.N., B.A. Director of Nursing Services
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation

or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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